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96TH CONGRESS, 1st Session | SENATE | REPORT No. 96-471

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT OF 1979

REPORT

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON

H.R. 934. A BILL FOR THE RELIEF OF BRIAN HALL AND VERA W. HALL

DECEMBER 10 (legislative day, NOVEMBER 29), 1979.—Ordered to be printed

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Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 934]

The Committee on Finance, to which was referred the bill (H.R. 934) for the relief of Brian and Vera W. Hall, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

I. SUMMARY OF THE BILL

As reported, the provisions of S. 505, the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979 (as well as provisions of S. 507 and S. 508) as amended by the committee and added as an amendment to H.R. 934, can be divided into four major parts: provisions relating to hospitals; provisions relating to skilled nursing facilities, intermediate care facilities and home health care; provisions relating to medical and other health services; and miscellaneous provisions. The summary presented below briefly outlines the bill as reported.

PRIVATE RELIEF PROVISIONS

The proposed legislation would extend the 18-month statutory time period allowable under section 1034 of the Internal Revenue Code, to permit Mr. Brian Hall and Mrs. Vera W. Hall of Laguna Beach, Calif., an adjusted sales price (that is, reduced basis) on their new residence for Federal income tax purposes. Essentially, the bill extends the advantages of section 1034 treatment so that claimants will not have to pay on capital gains tax on the sale of their old residence. Under the provisions of this legislation, the claimants would retroactively receive the benefit of an additional 51 days' grace period.

PROVISIONS RELATING TO HOSPITALS

1. The bill establishes a new method of reimbursement for routine operating costs for hospitals under the medicare and medicaid programs. The new mechanism, to be effective July 1, 1980, would provide for incentive reimbursement—rewarding hospitals whose routine operating costs are below average, and penalizing hospitals whose routine operating costs are substantially above average.

Comparisons among institutions would be facilitated by:

Classifying hospitals in groups, by bed size, location, type of hospital, or other categories found to be appropriate; and

Applying the reimbursement system initially to routine operating costs (for example, routine nursing, administrative, maintenance, supply and food costs), and excluding elements of routine costs which are not yet susceptible to equitable comparison, such as costs of capital, costs of education and training programs, malpractice insurance, energy, etc. Such excluded costs would continue to be reimbursed as under current law until such time as those costs can be compared.

A target rate for routine operating costs would be determined for each hospital by:

Calculating the average per diem routine operating cost for the hospitals in each classification group; and

Adjusting the personnel cost component of the group average to reflect the difference in wages in effect in each hospital's area.

Hospitals whose actual routine operating costs fell below their target rate would receive their costs plus one-half of the difference between their costs and their target rate, with the bonus payment limited to 5 percent of the target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their payment rate would have their reimbursement limited to 115 percent of the target rate. Beginning with the second year, the reimbursement limit would be reduced below the 115 percent level. To ease transition of the program, only one-half of the bonuses and penalties would be applied during the first two years of the program.

Provision is made for a hospital to demonstrate that its unusually high routine costs are caused by (1) underutilization of beds or facilities, but only where such beds or facilities are necessary to meet the needs of an underserved area, (2) an unusual patient mix which results in a greater intensity of routine care, (3) changes in services due to approved consolidations or sharing of services with another hospital, and (4) startup costs associated with a new hospital. Provisions are also included to assure that hospitals whose higher costs per day are more than offset by reduced lengths of stay would not be disadvantaged. To the extent that such additional costs could be justified, they would be excluded from the reimbursement criteria provided for in the bill.

If the Secretary is satisfied that a State hospital reimbursement control system would result in aggregate medicare and medicaid payments

to the hospitals located in that State for routine and nonroutine costs which are no greater than would otherwise be payable by medicare and medicaid under the system established by the bill, then payments to hospitals in that State could, at the State's request, be based on the State system. A State with an approved reimbursement control program would be reimbursed for the medicare program's proportionate share of the cost to the State of operating the State program. The State's medicaid program would pay its proportionate share of costs which would be matchable with Federal funds as an administrative expense. In addition, medicare and medicaid would pay their proportionate share of startup costs incurred following approval of a State reimbursement control program.

To the extent not specifically otherwise provided for under the bill, hospital reimbursement would be made by medicare and medicaid subject to and under the provisions of present law.

The bill requires the Secretary to appoint a 15-member Health Facilities Costs Commission. The Commission would monitor and study all aspects of the cost reimbursement program and propose such changes and refinements on a continuing basis as it found appropriate. The Commission would be directed to develop administrative and legislative recommendations to refine the method of reimbursing hospitals for routine costs and for the application of similar limitations to other hospital costs and to the costs of other providers of services, such as skilled nursing facilities, intermediate care facilities, home health agencies, and renal dialysis facilities.

2. The bill provides for including in payments to short-term hospitals, reimbursement for increased operating costs and, in the case of nonprofit institutions, for increased capital costs associated with the closing down or conversion to approved use of underutilized bed capacity or services. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, nonprofit hospitals could continue to receive capital allowances in the form of depreciation or interest on debt in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program and actually outstanding. Appropriate safeguards are included to forestall abuse or speculation.

3. The bill includes several changes in the current law limitations on medicare and medicaid payments related to certain capital expenditures by health care facilities and home health agencies. These changes also link reimbursement to the health planning law by requiring that the designated planning agency approve capital expenditures in excess of $150,000 (rather than $100,000, as under present law) as a condition of medicare and medicaid reimbursements for capital and direct operating costs associated with those expenditures. A special procedure is established for proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. All States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement subject to review by the Secretary. Section 1122(g) of the Social Security Act is amended to clarify that notice, approval and reimbursement

penalty requirements contained in that section with respect to approval of health care facility capital expenditures do not apply to simple changes of ownership (either by purchase, or under lease or comparable arrangement) of existing and operational facilities which create no new beds or services.

4. The bill changes the allowed rate of return on for-profit hospitals' net equity, which under present law is equal to 1½ times the current rate of return on Social Security trust funds. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in sec. 202 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits.

5. The bill provides for medicare, medicaid and the maternal and child health programs to share findings from a single audit where these programs reimburse the same entity on the basis of its reasonable costs.

6. The bill would exclude certain charitable donations for the purpose of determining the reasonable costs that are reimbursable under medicare and medicaid.

7. The bill authorizes the Secretary to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified personnel, the scope of services furnished, and the economic impact of structural standards which, if rigidly applied, would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not adversely affect the health and safety of patients.

8. The bill would recognize podiatrists, acting within the scope of their practice, for purposes of physician certification and participation as physicians in utilization review under medicare.

9. The bill provides that medicare would not reimburse any institution for a disproportionate share of costs until evidence is produced which justifies a specific adjustment under given circumstances for given facilities.

10. The bill provides that in certain cases medicare and medicaid payments to hospitals be made at the average skilled nursing facility, intermediate care-facility or detoxification facility payment rate (as appropriate), rather than the higher hospital rate, for patients medically determined by PSRO reviewers to need the lower level of care rather than acute hospital care. The bill also authorizes that benefits be provided and payment be made under medicare to qualified nonhospital inpatient detoxification facilities.

11. The bill authorizes a program of grants and loans to facilitate the conversion of surplus acute care hospital beds to long-term care beds in public and nonprofit hospitals.

12. The bill directs PSRO's to review areas of frequent overutilization (such as diagnostic tests routinely provided on admission without a physician's order and weekend elective admissions and preoperative stays for elective procedures in excess of one day) to assure that payment is made under medicare and medicaid only when such services are medically appropriate.

PROVISIONS RELATING TO SKILLED NURSING FACILITIES, INTERMEDIATE CARE FACILITIES, AND HOME HEALTH CARE

1. The bill permits a simplified cost reimbursement formula for medicare and medicaid reimbursement for small rural hospitals that wish to use acute care beds for long-term care services during periods of excess bed capacity.

2. The bill authorizes the Secretary (a) to validate, where he deems it necessary, State determinations on the eligibility of SNFs and ICFs under medicaid and to make independent and binding determinations on their participation and (b) to impose intermediate sanctions less severe than decertification when such facilities have been found to be out of compliance.

3. The bill prohibits the Secretary from imposing numerical limits on the number of home visits which might be made by skilled nursing home or intermediate care patients under medicaid.

4. The bill directs the Secretary of HEW to conduct a study of the availability and need for skilled nursing facility services under the medicare and medicaid programs and of the desirability and feasibility of requiring such facilities that wish to participate in one program to participate in both.

5. The bill directs the Secretary to review the present criteria for renewing benefits for skilled nursing care to assure that they are not too restrictive.

6. The bill would repeal existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facilities and home health services.

7. The bill repeals section 249 of the Social Security Amendments of 1972 so as to allow States, subject to certain requirements, to develop their own payment systems for skilled nursing facilities and intermediate care facilities.

8. The bill removes the requirement in existing law that limits medicare home health benefits to 100 visits under part A and 100 visits under part B and the requirement that a beneficiary has to be an inpatient in a hospital for at least three days before he can qualify for part A home health benefits. Other provisions related to home health services under medicare and medicaid would: (a) change the plan of care requirements to allow physician assistants and nurse practitioners in rural areas to establish plans of care and to require that plans of care include programs for patient education; (b) establish guidelines for determining the direct and indirect incurred costs of home health services; (c) establish demonstration projects for utilization review of home health services; (d) permit payment for home health services provided in adult day care centers; ard (e) redesignate "home health aides" as "homemaker–home health aides".

PROVISIONS RELATING TO MEDICAL AND OTHER HEALTH SERVICES

1. The bill includes incentives for physicians to accept assignment by expediting payment of claims from "participating" physicians—i.e., physicians who accept assignment for all their medicare services. It

also authorizes five to ten pilot projects to experiment with ways of encouraging physicians to accept assignments.

2. The bill authorizes the Secretary to initiate the development and approve the use of terminology systems and relative value schedules by physicians in billing medicare, medicaid, and for other purposes.

3. The bill extends for an additional year (until October 1, 1979) the date for implementation of Section 227 of P.L. 92–603 relating to reimbursement of teaching physicians. It also provides an alternate reimbursement method for teaching teams in hospitals which do not qualify for fee-for-service reimbursement for medical services under medicare.

4. The bill permits medicare reimbursement to be made to free-standing ambulatory surgical centers and physicians performing surgery in their offices for the use of surgical facilities needed to perform a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient basis but can, consistent with sound medical practice, be performed on an ambulatory basis. In the physician's office, the rate would encompass reimbursement for the facilities and physician, and for related services including pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure. In the case of an ambulatory surgical center, the overhead allowance may be paid directly to the center and the professional fee directly to the physician(s).

The physician performing surgery in his office would be fully compensated for his overhead costs through this rate if he accepts an assignment; there would be no deductible and coinsurance.

Similarly, deductible and coinsurance amounts would be waived for the physician's fee when the physician accepts assignment for hospital outpatient surgery.

The bill would also eliminate the financial incentives to unnecessarily utilize hospital care in cases where needed diagnostic services are provided in the hospital's outpatient department 7 or fewer days prior to the patient's admission. A physician performing specified preoperative services (as defined by the National Professional Standards Review Council) during this period would receive reimbursement equal to 100 percent of medicare's reasonable charge if he agreed to accept assignment.

5. The bill modifies existing medicare criteria for determining reasonable charges for physician's services. It requires calculation of statewide median charges (in any State with more than one locality) in addition to the local prevailing charges. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect—it would operate, to the extent given charges exceed the statewide median by more than one-third—to preclude raising them.

The bill would also permit new physicians in under-served localities to be reimbursed at the 75th percentile (rather than the 50th) as a means of encouraging doctors to move into low-fee, physician shortage areas. It would also permit physicians presently practicing in shortage areas to have the fees they generally are charging recognized as reasonable, up to the 75th percentile.

6. The bill prohibits the Secretary from routinely releasing medicare information, and provides that State agencies shall not be required to release medicaid information, relating amounts paid to physicians under the respective programs, except as otherwise specifically required by Federal law.

7. The bill amends present law to provide for direct payment under medicare to allergists for preparation of a reasonable supply of antigens which would be dispensed or administered by or under the supervision of another physician.

8. The bill includes a technical change that would permit payment by medicare for care directly to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill. Under present law, medicare can only pay where the physician accepts an assignment or where the family has actually paid the bill. Thus, in some cases where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

9. The bill would repeal the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

10. The bill requires the Department of HEW to conduct a study of the present methods of reimbursement for durable medical equipment and to recommend changes that are appropriate. The Secretary would be required to submit a report on this study within 12 months of enactment.

11. The bill waives the $60 medicare deductible in applying special laboratory billing procedures under medicare.

12. The bill waives the medicare Part B $60 deductible with respect to services provided in rural health clinics.

13. The bill recognizes comprehensive outpatient rehabilitation facilities as "providers of services" under the medicare program if they meet specific conditions of participation. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction, diagnostic, therapeutic, and restorative services to outpatients. Reimbursement to such facilities would be authorized under part B of the program, based on the costs they incur in furnishing covered services, including: physicians' services, nursing care, physical therapy, occupational therapy, speech pathology, respiratory therapy, social and psychological services, prosthetic and orthotic devices, drugs and biologicals (which cannot be self-administered), supplies, appliances, equipment (including the purchase of rental equipment), and certain other items and services necessary for the rehabilitation of the patient. The bill thus permits reimbursement for rehabilitation services provided in a certified outpatient rehabilitation facility to be made on the same basis as these services are presently reimbursed if they are provided in a hospital.

14. The bill permits payment for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care. Ambulance transportation to receive radiation therapy and other specialized services could also be covered under certain circumstances.

15. The bill extends the coverage of dental services under medicare to include any services performed by a doctor of dental medicine or

dental surgery which he is legally authorized to perform in cases where the services would be covered if performed by a physician. The bill also would provide that payments would be made under Medicare for inpatient hospital stays that are justified because of the severity of the dental procedure.

16. The bill authorizes medicare part B reimbursement to optometrists for services related to aphakia which are within the scope of licensed optometric practice, and which are covered under present law when provided by a physician.

17. The bill would delete the requirement for chiropractic coverage that a subluxation be demonstrated to exist through an X-ray. Under the bill, other clinical findings would suffice in lieu of an X-ray.

18. The bill eliminates the present exclusion under medicare of services related to the treatment of plantar warts.

19. The bill requires the newly established Health Facilities Cost Commission to give priority to the development of limitations on reimbursement for hospital outpatient service costs. Further, the Secretary is required to issue regulations providing for the establishment of such limitations.

MISCELLANEOUS PROVISIONS

1. The bill protects the confidentiality of certain kinds of PSRO information that identify an individual patient, provider, practitioner, supplier, or reviewer except in specified cases.

2. The bill provides, except under certain specified circumstances, that compensation paid to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized for medicare-medicaid reimbursement purposes where the payments (in whole or part, in cash or kind) are based upon percentage arrangements. Percentage arrangements involving payment to hospital based physicians would nevertheless be recognized if the amount of reimbursement does not exceed an amount that would reasonably have been paid under an approved relative value schedule which takes into consideration the physician's time and effort.

3. The bill terminates the Health Insurance Benefits Advisory Council.

4. The bill requires HEW to adopt, to the extent feasible, standarized claims forms for medicare and medicaid within 2 years of enactment.

5. The bill provides that Medicare would not be the payor of first resort in cases where the patient is involved in an accident and his care can be paid for under liability coverage of the individual who was at fault.

6. The bill provides that adverse decisions of the Provider Reimbursement Review Board involving actions brought jointly by several providers may be appealed to the Federal district court for the group's headquarters office (or for the appellant having the most money at issue, if the group is not under common ownership) is located.

7. The bill permits States to deny medicaid eligibility for up to one year in cases where an aged, blind, or disabled person qualifies by disposing of significant assets by either giving them away or selling them for less than fair market value in order to establish medicaid eligibility.

8. The bill allows a State to purchase laboratory services and medical devices for its medicaid population through competitive bidding or other arrangements for a 3-year experimental period.

9. The bill gives States which do not currently have a "buy-in" agreement with medicare for all medicaid eligibles an additional 12 months to enter into such arrangements.

10. The bill extends for two years (until October 1, 1982) the period when increased Federal matching is available for funding of State medicaid fraud control units.

11. The bill provides that Federal medicaid funds may not be drawn upon until they are actually needed by the State to pay providers and practitioners.

12. The bill provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under the Social Security Act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the program affected.

13. The bill waives requirements of the human experimentation statute which may otherwise be held applicable with respect to coverage, copayments, deductibles or other limitations on payment for services for purposes of medicare and medicaid. The bill further provides that the Secretary, in reviewing any application for any experimental, pilot or demonstration project pursuant to the Social Security Act, would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application.

14. The bill authorizes the disclosure of medicaid information to governmental agencies that have legal authority to conduct medicaid audits.

15. The bill provides for demonstration programs in up to 12 States to formally train AFDC recipients as homemaker home health aides. These individuals would then be employed by public and nonprofit private agencies to provide supportive services to people, primarily the aged and disabled, who would reasonably be expected to require institutional care in the absence of these services. The homemaker and home health services would be available at no cost to individuals whose income does not exceed 200 percent of the State's need standards. The program, authorized over a 5-year period, would be administered by a State health services agency designated by the Governor. Approved programs would receive 90 percent Federal funding.

16. The bill authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) an institution of higher learning.

17. The bill provides that the Administrator of the Health Care Financing Administration would be appointed by the President with the advice and consent of the Senate. The provision would apply to individuals appointed to the position after the date of enactment.

18. The bill requires local Professional Standards Review Organizations (PSRO's) to formally involve health care practitioners who hold independent hospital admitting privileges in the review of care ordered or rendered by these practitioners.

19. The bill expands the membership of the National Professional Standards Review Council to include a doctor of dental surgery or dental medicine and a registered nurse.

II. General Explanation of the Bill

Part A—Private Relief Provisions

SECTION 101—RELIEF OF BRIAN AND VERA HALL

On October 24, 1975, Mr. and Mrs. Hall purchased a new residence, located at 472 Los Robles, Laguna Beach, Calif. However, they were unable to sell their prior residence, located in Glendale, Calif., until June 15, 1977. This delay was due in large part to construction of, and controversy surrounding, the nearby Glendale Freeway. By the time the claimants had finally sold their Glendale property, the statutory 18 months period, allowing for the nonrecognition of a capital gain with respect to the sale of an old residence, had passed. Specifically, the claimants' 18-month "rollover" period expired on April 24, 1977. See: 26 U.S.C. 1034.

Prior to the actual expiration of the statutory eligibility period, the claimants sought to request an administrative waiver of the 18-month period from the Internal Revenue Service. However, they were discouraged from formally filing for such a waiver by personnel in the local Hollywood, Calif., IRS office. The indication was that such a procedure would only be futile. The claimants argue that a marked inconsistency exists in the IRS treatment of residential property, as opposed to commercial property, in similar fact circumstances. They cite the fact that the Internal Revenue Code and certain revenue rulings permit the administrative waiver of the capital gains holding period on certain types of commercial properties and inquire why the parallel provision dealing with residential property can't also be administratively extended under compelling circumstances. See: 26 U.S.C. 1033(a)(B)(ii); Treas. Reg. 1.1033(a)-(2)(c)(3). They argue that section 1033 of the Internal Revenue Code allows a 2-year period (which can also be extended for "reasonable" periods of time) where property is sold under the threat of condemnation or is otherwise involuntarily converted. Claimants feel that the nearby freeway construction placed them in a near-condemnation situation.

The committee was satisfied that the ability of the claimants to sell their Glendale property was directly and negatively affected by the construction of, and controversy surrounding, the nearby Glendale Freeway. The lack of marketability was clearly affected by the freeway, located less than 200 yards away from the Halls' property. The source of long and bitter controversies, plans for the Glendale Freeway date back over 18 years, and while some construction on the project began in 1967–78, the planned completion date of 1972 has long since passed. In fact, the highway is still not completed. The delays, in part, were caused by the lack of availability of Federal funds and the numerous changes in Federal guidelines during the planning and construction periods. while the committee recognizes that the delays in

such a federally funded highway project are not unusual, it was felt when coupled with the inflexibility of the IRS on the administrative waiver question, the circumstances did give rise to a case for private relief.

Part B—Provisions Relating to Hospitals

SECTION 202—CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

Expenditures for hospital care have been increasing at double-digit rates for many years. Preliminary estimates for calendar year 1978 indicate that hospital expenditures for that year were 12 percent higher than 1977. Expenditures for hospital care, $76 billion in 1978, represent 40 percent of all national health expenditures. Hospital expenditures in fiscal year 1978 represent 3.6 percent of the GNP and $341 per capita. Historically, hospital costs per patient-day have risen much more rapidly than consumer prices in the economy as a whole. For example, while the general level of consumer prices rose by about 170 percent from 1950 to 1978, the average cost of a day of hospital care increased by more than 1,800 percent.

This rapid growth in the costs of hospital care has focused increasing attention on hospitals and the present methods currently used to reimburse hospitals. Cost-based reimbursement in particular has been the subject of widespread criticism. There is little in the way of pressure on hospitals so paid to contain their costs, since any increases are simply passed along to the third parties that reimburse on a cost basis. The present "reasonable costs" procedures under the medicare program are not only inherently inflationary—because there are no effective limits on what costs will be recognized as reasonable—but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

In a nongovernmental attempt to moderate the rate of increase in overall hospital expenditures, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals and other health care associations are leading a cost containment activity at the State level. This so-called "Voluntary Effort" should not be discouraged or impaired by Federal agencies through legal or other means before it has had reasonable opportunity to demonstrate success or failure.

The bill does not seek to replace the Voluntary Effort but rather to reform the method of reimbursement for hospitals under the medicare and medcaid programs. Under the new method, to be effective with hospital reporting periods that begin after June 30, 1980, reimbursement for most of a hospital's inpatient routine costs (essentially costs other than ancillary expenses such as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals. Those hospitals whose routine operating costs were below the average for comparable hospitals would be rewarded with incentive payments, and payments to those hospitals with routine operating costs which are substantially above the average would be reduced.

This initial system, described more fully below, would be studied and extended on an as-ready basis. The committee expects that the

new system will be extended to hospitals' ancillary costs and other costs that are excluded initially as soon as adjustments for patient-population differences and other methodological prerequisites are developed. Based on recommendations of a proposed Health Facilities Cost Commission, a permanent system would be developed over time which would establish payment rates and provide incentive payments with respect to all hospital costs and to costs of other institutions and organizations which are reimbursed on a cost basis. Continuing efforts would be made by the Commission to refine and improve the system of classification and comparison so as to achieve the greatest equity possible. The Secretary would appoint the members of the new Health Facilities Cost Commission on or before January 1, 1980. The Commission would consist of 15 persons who are expert in the health facilities reimbursement area. At least five of the members would be representatives of hospitals (and other providers which are subject to the new reimbursement method); at least five would be representatives of public (Federal, State, and local) health benefits programs; and the remainder would be persons who, through training, experience or attainments, are particularly and exceptionally well qualified to serve in carrying out the Commission's functions.

The method of reimbursement established by the bill for routine hospital costs would be as follows. Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria established by the Secretary; and

2. Comparing the routine costs (as defined for purposes of applying the medicare routine cost limits under present law) of the hospitals in each group, except for the following routine variable costs: capital and related costs; cost of approved education and training programs for health care personnel; costs of interns, residents and nonadministrative physicians; energy costs; and malpractice insurance costs.

When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category. The Health Facilities Cost Commission should give priority to the development and evaluation of alternative definitions and classifications for this category of medical schools. The Commission should ensure that the treatment of these medical center/tertiary care/teaching hospitals accurately reflects the hospital's role as a referral center for tertiary care patient services, as a source for the development and introduction of new diagnostic and treatment technologies, and/or as the source of care for a high concentration of patients needing unusually extensive or intensive patient care services provided in routine service cost centers. In addition, these hospitals generally provide a broad range of graduate medical education programs and undergraduate medical clerkships. The committee recognizes that some medical schools, because of their organization and objectives, have more than one primary affiliate, and the primary affiliate classification should provide for the possibility of including more than one hospital in unusual situations. The primary affiliates category should not include affiliated hospitals which are not primary affiliates within the meaning of the concept described above.

A per diem target rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost for each group of hospitals under the classification system (excluded would be newly-opened hospitals and hospitals which have significant cost differentials because they do not fully meet the standards and conditions of participation as providers of services); and
2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of the group's average per diem routine costs for area wage differentials. In the first year of the program only, an adjustment would be allowed where the hospital can demonstrate that the wages paid to its employees are significantly higher than the wages other employees in the area are paid for reasonably comparable work (as compared to the ratio for other hospitals in the same group and their areas).

The Secretary would adjust the per diem target rates by adding an annual estimated percentage increase in the cost of routine goods and services hospitals purchase, with an adjustment for actual changes at the end of a hospital's accounting year.

The committee recognizes that all the data for precise determination of routine operating costs and the labor and nonlabor components of such costs may not be available from cost reports for accounting years that begin prior to July 1, 1980. To the extent necessary, the Secretary will be expected to make reasonable estimates on the basis of the data available to him. That it is reasonably related to actual hospital cost experience.

Hospitals whose actual routine operating costs fall below their target rate would receive their actual costs plus one-half of the difference between their costs and their target rate with the bonus payments limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceed their target rate, but are no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their target rate would have their reimbursement limited to 115 percent of the target rate.

In the second and subsequent years of the program, the hospital's maximum payment rate would be increased by the actual dollar increase in the average target rate for its group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

To ease transition of the program, only one-half of the bonuses and penalties would be applied during the first two years.

Adjustments to a hospital's target rate would be made for changes in the hospital's classification. Hospitals which manipulate their patient mix or patient flow, reduce services, or have a large proportion of routine nursing services provided by private-duty nurses would also be subject to an adjustment. Also, a hospital would qualify for any higher target rate that is applicable to the hospitals placed in the bed-size category which contains hospitals closest in bed size to its actual bed size. The target rate for hospitals which have average lengths-of-stay which are less than other hospitals in the same category could be calculated by multiplying the average reimbursement per patient stay for the hospital's category by the number of patient stays for that hospital, not to exceed its actual routine costs.

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Adjustments would be made to the target rates of hospitals which demonstrate that their costs exceed their target rates because of (1) unusually high standby costs justified by low utilization in underserved areas; (2) atypical cost patterns of newly opened hospitals; (3) services changed for such reasons as consolidation, sharing, and approved addition of services (e.g., costs associated with low utilization of a new wing); and (4) greater intensity of patient care than other hospitals in the same category. Some hospitals have consistently shorter lengths of stay in treating patients than their group average for a reasonably similar mix of patients with comparable diagnoses. To the extent that a hospital can demonstrate that the shorter stays result from an "intensity" of service which makes it necessary for the hospital to incur additional costs, such additional costs per day would be recognized under the "intensity" exception provision, except where a hospital has had its target rate calculated on the cost-per-stay basis (to take into account shorter lengths of stay).

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has established a hospital reimbursement control system which applies at least to the same hospitals and kinds of costs as are subject to the proposed Federal reimbursement reform system and (b) the State requests use of its own system and demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursement costs for hospitals in the State will be no greater than if the Federal system had been applicable. If the reimbursement system were not established by the State but in all other respects it meets the criteria for an exemption under the provisions of the bill, the reimbursement system would be considered to be established by the State if the State elects to have it so treated.

A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal program for any two-year period would be covered under the Federal limits beginning with the subsequent year. The amount of the excessive payments would be recouped over subsequent periods through appropriate reduction (not in excess of one percent annually) in the cost limits otherwise applicable.

States which obtain a waiver would be reimbursed for the medicare program's proportionate share of the cost the State incurs in operating the State reimbursement control system. The State's medicaid program would pay its proportionate share of costs, which would be matchable with Federal funds as an administrative expense.

Medicare and medicaid would also pay a proportionate share of startup costs incurred by a State following approval of State reimbursement control systems. The Federal share of the startup costs would be the same proportion as the Federal payment for inpatient hospital costs in the State bears to the total inpatient hospital costs which are subject to the State system. For example, if the Federal Government pays, through medicare and medicaid, 40 percent of the total hospital costs in the State that are subject to the State system, it would be liable for 40 percent of the State program's startup costs.

The committee expressed concern over the possibility that the new limits on reimbursement might lead to increased costs for other payors. The new Health Facilities Cost Commission should review the op-

eration of the new medicare-medicaid hospital reimbursement system and report on the extent, if any, to which hospitals bill other pavors to cover costs disallowed by medicare and medicaid.

The Commission is expected to also report to the Congress when, in its opinion, a State has, under its approved ratemaking system, established reimbursement under medicare and medicaid at levels so much below what would otherwise be payable in the absence of the State system, as to actually impair the ability of the hospitals to provide necessary care at reasonable cost.

If the HEW Secretary proposes to modify the method of reimbursement for reasonable costs under titles V, XVIII, and XIX of the Social Security Act, he must submit such proposals to the Health Facilities Costs Commission. If the Commission disagrees with the proposals, regulations implementing such proposals must be submitted to the Congress and may not become effective for 60 days. In addition, section 249 of this bill requires the Commission to give priority to studying and recommending to the Secretary limits on reasonable costs and charges for outpatient services.

SECTION 203—PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

Studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered by the hospital. In addition there are the continuing expenses associated with maintenance, and nonpatient services involved in keeping an empty bed ready for use. Surplus beds contribute to cost escalation in other less obvious ways. Unnecessary or underutilized hospital facilities can drain scarce manpower and generate scarcities of trained personnel, which in turn drive up salaries and may even threaten the quality of care. Coupled with the availability of hospitalization insurance, bed surpluses tend to generate pressures to use high cost hospital beds rather than less expensive alternative forms of care. The development of alternatives to inpatient facilities, such as primary care and community home care programs, suffers when investment is needlessly diverted to underutilized hospital bed capacity. Estimates of the savings that would accrue from closure or conversion of unused or underutilized facilities range from $2 billion to $4 billion annually, depending on whether the change involves closure or conversion of a particular service department as opposed to a whole hospital.

The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals. A hospital could apply for such payments *before or after* the conversion or closing takes place. In the case of for-profit short-term hospitals, reimbursement would be limited to increased operating costs. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, payments could be continued for reasonable capital costs in the

form of depreciation allowances, or reimbursement for interest payments which would ordinarily be applied toward payment of outstanding debt which had been incurred in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

The Secretary would establish a Hospital Transitional Allowance Board which would consider requests for such payments. Appropriate safeguards would be developed to forestall any abuse or speculation. Prior to January 1, 1983, not more than 50 hospitals could be paid a transitional allowance in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering severe financial penalty. The Secretary of HEW is required to report to the Congress, on or before January 1, 1982, an evaluation of the effectiveness of the program and any recommendations.

The committee recognizes that facility which is generally underutilized, and which would therefore be potentially eligible for a transitional allowance to finance a facility conversion, may be the sole or primary source of care for needed health services in the community. It is the intent of this committee that the availability of a transitional allowance not encourage the conversion of a facility that is needed in the community. Therefore, it will be necessary for the Hospital Transitional Allowance Board to determine that the facility conversion will not have an adverse impact on access to needed health care services before the Board may recommend that the Secretary establish a transitional allowance for the hospital. Only in those cases in which reasonable access to needed health care services will not be jeopardized may a transitional allowance be recommended.

SECTION 204—FEDERAL PARTICIPATION IN CAPITAL EXPENDITURES

The bill authorizes certain changes in the current law limitation on medicare and medicaid payments related to capital expenditures by health care facilities and home health agencies in order to require approval of such expenditures as a condition of reimbursement for both capital and direct operating costs. The bill also establishes a special procedure for review and approval of capital expenditures in metropolitan areas involving more than one State or jurisdiction.

Concern over the cost consequences of unnecessary capital investment in health care facilities has been translated into a variety of legislative and administrative actions at the Federal, State, and local levels. Starting in the mid-sixties, States began enacting legislation requiring the issuance of a certificate of need prior to construction, expansion, modernization, or acquisition of hospital plant or equipment. With the enactment of the Social Security Amendments of 1972, the Federal Government formally adopted the certificate of need concept. Under section 1122 of the Social Security Act, the Secretary is required to seek contract agreements with the States for their review of capital investments in hospital and other health care facilities which exceed $100,000, change the bed capacity, or substantially change the services

in the facility. Under such contracts, the Secretary may deny medicare and medicaid reimbursements for depreciation or interest costs if they were incurred without prior State approval.

The bill provides for changes to be made in the current law limitations on medicare and medicaid payments related to capital expenditures by health care facilities and home health agencies. These changes link the procedure directly to the Federal health planning law (Public Law 93–641) and require that the designated planning agency (the State Health Planning and Development Agency as designated under section 1521 of the Public Health Service Act) approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement for both capital and (estimated) direct operating costs associated with those expenditures. The committee believes that regulations developed by the Department to implement this section should allow for speedy replacement of capital plant and equipment in certain emergency situations.

A special procedure is established for approval of proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. In such cases the designated planning agencies of all the States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement, subject to review and reversal by the Secretary.

The bill amends Section 1122(*g*) of the Social Security Act to clarify that notice, approval and reimbursement penalty requirements contained in that section with respect to approval of health care facility capital expenditures do not apply to simple changes of ownership (either by purchase, or under lease or comparable arrangement) of existing and operational facilities which create no new beds or services.

The bill clarifies that these provisions also apply to health maintenance organization hospitals and home health agencies. Home health agencies that seek to participate in medicare or medicaid on or after October 1, 1979, would be required to have section 1122 approval as a condition of reimbursement. The concern has been expressed that some State Health Planning and Development Agencies (SHPDAs) or other agencies designated to make determinations under Section 1122 of the Social Security Act or certificate of need laws might deny approval of projects of Health Maintenance Organizations and other types of health facilities not on the basis of lack of need for the services, but because of bias against such systems of providing care. This provision would allow the Secretary to reimburse capital costs and estimated related operating costs to health facilities despite SHPDA disapproval in instances where he found discrimination had occurred and where he found such expenditures to be reasonable.

SECTION 205—RATE OF RETURN ON NET EQUITY FOR FOR-PROFIT HOSPITALS

Under present law, the medicare program allows for-profit hospitals a return on net equity capital invested and used in providing patient care. The amount allowable is determined by applying to the proprietary hospitals equity capital one and one-half times the rate of return earned on Social Security trust funds. This formula produced a rate of

return of 13.5 percent in March, 1979. Profitmaking hospitals argue that this return compares unfavorably to that of comparable businesses.

The bill changes the allowed rate of return on for-profit hospitals' net equity. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in section 202 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits. The new rates of return, payable at the time of the hospital's final cost settlement, would become effective at the same time as the new incentive reimbursement system—i.e., hospital accounting periods beginning on or after July 1, 1980.

The committee also anticipates that at such time as skilled nursing facilities are reimbursed under an appropriate system of classification and comparison and made subject to incentives and penalties, legislation will be enacted to provide these facilities returns on equity similar to those established by this section for hospitals.

SECTION 206—COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

The bill provides for the coordinated use of audit findings in the administration of medicare, medicaid and the maternal and child health program.

The committee has been concerned that the duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as a hospital, skilled nursing facility, or home health agency) participating in the program.

The committee bill therefore requires that, if an entity provides services reimbursable on a cost-related basis under title XVIII and titles XIX or V, audits of books, accounts, and records of that entity for purposes of the State Federal programs are to be coordinated through common audit procedures. Ordinarily, it is expected that the common audit would be performed for the purposes of reimbursement under title XVIII. However, in those cases where the Secretary finds, in the interest of efficiency and economy, that a State audit would be more appropriate, the State could, if it agrees to do so, perform the common audit for the three programs.

When a State declines to participate in a common audit, the Secretary is to reduce payments that would have been made to the State under title V or XIX by the amount attributable to the duplicative State audit activity. A State participating in the common audit procedure would continue to receive Federal matching for administrative costs associated with any additional or supplemenal audit data or audits that may be necessary under their medicaid and maternal and child health programs. The committee expects that the common audits will be carried out in timely fashion in order to expedite the interprogram coordination.

SECTION 207—ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR HEALTH CARE

Under present medicare policy, in determining the reasonable costs of services furnished by a hospital, skilled nursing facility, outpatient

rehabilitation facility or other provider of health services, unrestricted grants, gifts and income from endowments are not deducted from reimbursable costs of the provider. The bill provides a statutory base for this policy.

In addition, the committee encourages States, when developing their hospital ratemaking programs, to treat unrestricted gifts, grants and income from endowments in the same fashion as under medicare and medicaid.

SECTION 208—FLEXIBILITY IN APPLICATION OF STANDARDS TO RURAL HOSPITALS

Under present medicare law, a hospital must satisfy certain statutory conditions of participation relating to health and safety standards, physical plant, organizational arrangements, and qualified medical, nursing, and technical staff. The Secretary is authorized to prescribe additional requirements he finds necessary in the interest of the health and safety of patients. Current law also provides authority for the Secretary to waive the statutory 24-hour registered professional nursing service requirement in the case of a rural hospital which he determines is needed to serve the individuals in the area and is making a good faith effort to comply with the 24-hour requirement, but where such compliance is impeded by a lack of qualified nursing personnel in the area. This waiver authority expired on December 31, 1978.

Many professional people contend that medicare's health and safety standards are designed primarily for large urban hospitals and that, consequently, the rigid application of these standards to rural hospitals, many of which provide a lesser range of services and have limited access to the services of technical personnel, creates unnecessary financial and management burdens.

The bill provides the Secretary with permanent authority to apply medicare standards to rural hospitals more flexibly to take into account the availability of qualified technical personnel, the scope of services furnished, and the economic impact of structural standards which, if rigidly applied, would result in unreasonable financial hardship for a rural hospital; but only to the extent that such differential application of the standards does not jeopardize or adversely affect the health and safety of patients.

Under this provision, it would still be necessary for the Secretary to assure that there is compliance with appropriate health and safety requirements. For example, with respect to the requirements for nursing services applicable after December 31, 1978, the Secretary may provide for a temporary waiver, on a case-by-case basis, of the requirements if he determines that the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area; if a registered nurse is present on the premises to render or supervise the nursing service during at least the regular daytime shift; and if the employment of such nursing personnel as are available to the facility during such temporary shortage period will not adversely affect the health and safety of patients.

The bill requires that health and safety requirements be applied by the Secretary to rural hospitals in such a way that personnel require-

ments take into account the availability of technical personnel and the educational opportunities for technical personnel in the hospital's area, and the scope of services furnished by the hospital. By regulation, the Secretary must permit the continued participation in the medicare program of a rural hospital even if personnel requirements are not fully met, if the facility is making good faith efforts to comply with the personnel requirements and the health and safety of patients are not adversely affected. The underlying premise, however, is that the Secretary will exercise the authority to apply standards with some flexibility only when he is satisfied that the health and safety of patients will not be jeopardized and that those services rendered by the affected facilities are delivered in a manner that is consistent with reasonable standards for such facilities. If the Secretary is not satisfied that the application of flexible standards will not adversely affect the health and safety of patients, he may exercise authority to limit the scope of services provided by the facility.

SECTION 209—CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS

Under the bill, podiatrists, acting within the scope of their practice, would be recognized by medicare for purposes of physician certification and participation as physicians in utilization review. This recognition would be extended where consistent with State law and the policies of the health care institutions involved.

As a condition of payment for hospital and other services covered under medicare, existing law requires that a physician certify as to the medical necessity for the service. Also, medicare requires that the utilization review committee of a hospital or skilled nursing facility include at least two physicians. For neither purpose does a podiatrist qualify as a "physician."

Since medicare covers as "physicians' services" the services performed by podiatrists within the scope of their practice, the committee concluded that medicare should also recognize podiatrists as physicians for purposes of physician certification and participation in utilization review of podiatric services.

The bill extends this recognition to certification and utilization review activities that are consistent with the functions the podiatrist is legally authorized to perform in the State where he practices, and where this recognition is consistent with the policies of any health care institution that is involved. With respect to utilization review, a podiatrist acting as a physician member of a utilization review committee would not take the place of an M.D. or osteopath as one of the two required physician members of the committee.

SECTION 210—APPORTIONMENT OF PROVIDER COSTS

Under a policy that medicare adopted in July 1969, hospitals are reimbursed for a disproportionately large share of the costs of routine nursing care on the theory that older hospital patients require an above-average amount of routine nursing services per day. This inpatient routine nursing salary cost differential is 8½ percent of the inpatient routine nursing salary cost. However, there was no objective, convincing evidence that this "plus factor" was warranted at that time,

either in the case of individual hospitals or in the aggregate. Since July 1969, when the inpatient routine nursing salary cost differential became effective, there have been changes in medicare law, changes in the way services are furnished, and changes in the way medicare reimburses for routine services that make the cost differential even less tenable today. One argument against the cost differential is that the increase in the number of below-age-65 population beneficiaries has made an average routine per diem amount for all beneficiaries (excluding recognition of any differential) more appropriate. Also, with the growth of special-care beds (intensive care, coronary care, etc.), there has been a shift of the intensely ill from general routine-care areas to these special-care units. There has been greater utilization of these special-care units than of routine care areas by medicare beneficiaries. More intensive nursing care is now being given in these special-care units, making the nursing cost differential for routine services unnecessary.

The bill provides that no medicare payments may be made if the payment exceeds the proportional share of the cost, as measured by days of utilization or provider charges, until such time as evidence can be produced which, in the judgment of the Comptroller General, and concurred in by the Secretary of HEW, justifies a specific plus factor as warranted under particular circumstances for certain facilities. It is the committee's intent that the Comptroller General will initiate the required studies without delay and report his findings promptly.

SECTION 211—REIMBURSEMENT FOR INAPPROPRIATE INPATIENT HOSPITAL SERVICES

Professional Standards Review Organizations (PSRO's) have found thousands of medicare and medicaid patients being kept in costly acute-care hospital beds instead of being appropriately placed in nursing facilities or detoxification units. The situation occurs most frequently in those areas where there is a surplus of hospital beds and a shortage of long-term care beds.

To prevent this wasteful expenditure of public funds and encourage a more rational use of health resources, the bill provides that, effective not later than April 1, 1980, medicare and medicaid payments to hospitals would be made at the average skilled nursing facility (SNF), intermediate care facility or detoxification facility payment rate (as may be appropriate) in the State, rather than the much higher hospital rate, for patients medically determined by PSRO reviewers to need care in such a lower-cost facility. (In no case, however, could a facility that has a unit that can provide the appropriate level of care be paid more under this provision than it could be paid if it had placed the patient in the appropriate unit.) For example, if the PSRO determined that a hospitalized medicare patient could more appropriately be cared for in a SNF, and that he would be eligible for medicare benefits if he were an inpatient in such a facility, medicare payments for his hospital care would be paid at the SNF rate. Days of care paid by medicare at the reduced, SNF rate would be counted against the patient's eligibility for skilled nursing facility benefits, and the skilled nursing facility benefit coinsurance rates would also be applicable. To prevent undue hardship, the limitation would not apply in those geo-

graphic areas where the appropriate State or local planning agencies certify that there is no general excess of hospital beds and there is a shortage of long-term care beds.

In addition, the bill provides for payment to be made under medicare for inpatient detoxification services in a freestanding facility that is not a hospital. The "detoxification facility services" to be covered would be the same as those that are reimbursable when provided in a hospital. The term "detoxification facility" means a public or nonprofit facility other than a hospital which (a) is engaged in furnishing the above services to inpatients; (b) is either accredited by the Joint Commission on Accreditation of Hospitals as meeting its Accreditation Program for Psychiatric Facilities standards (1979 edition) or found by the Secretary to meet such standards; (c) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and (d) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.

A physician (qualified to make such determinations) who has examined the patient prior to initiation of detoxification must certify that he needs to be detoxified on an inpatient basis.

Reimbursement for detoxification services would be made under medicare—Part A, on a reasonable cost basis, with no deductible or coinsurance.

The Secretary shall study and make recommendations, within 18 months of enactment, concerning the appropriateness of extending coverage to post-detoxification rehabilitation and to outpatient detoxification. The Health Facilities Cost Commission would review and recommend a method of classifying and comparing detoxification facilities in time to permit application of the reimbursement methodology within two years of enactment.

PSRO's would be directed to review the appropriateness of the services furnished by detoxification facilities for which Medicare reimbursement is claimed. The committee understands that 3–5 days will ordinarily be sufficient for patients to complete the detoxification process.

SECTION 212—CONVERSION TO LONG-TERM CARE FACILITY

To deal further with the deficiencies in the allocation of health resources, the bill authorizes a program of grants and loans to facilitate the conversion of surplus acute care hospital beds to long-term care beds in public and nonprofit hospitals. An acute care bed for these purposes would be one which was actually maintained and available for patient use during the preceding year. Priority would be given is not a hospital. The "detoxification facility services" to be covered to hospitals located in high cost urban areas and to complete conversion of public hospitals to extended care as opposed to partial changeover.

To carry out this program, a total of $100 million in grant funds and loans are authorized for the 2-year period consisting of fiscal years 1980 and 1981; not more than $50 million of the total may be

used for making grants. Grants may be made for amounts up to that portion of the conversion costs which equals the average proportion of the hospital's patients in the two full accounting years preceding the conversion which were medicare-medicaid beneficaries. Loans may be committed in fiscal 1980 up to the balance of a hospital's conversion costs to the extent they are not covered by a grant or loan made under any other Federal program.

The Secretary must assure that such grants and loans are coordinated with any similar aid provided under Federal law and with the actions of the Hospital Transitional Allowance Board taken under section 1118. It is expected that the Secretary would also assure that such grants and loans are consistent with State and local planning activities.

Where a hospital converts acute care beds to long-term care usage under this provision, it could be permitted to reconvert those beds back to acute care usage within a period of 2 years without being subject to the section 1122 approval process.

The committee expects the Secretary to develop regulations and exceptions with respect to provider standards and conditions of participation which will allow, to the maximum extent feasible, and on an exceptions basis, for ease and simplicity in converting from acute care hospital beds to long-term care beds where the health and safety of patients is not jeopardized.

SECTION 213—PSRO REVIEW OF HOSPITAL ADMISSIONS, ROUTINE TESTING AND PREOPERATIVE STAYS

Present policies direct PSRO's to review the appropriateness of hospital services received by medicare and medicaid patients. This review has been limited largely to a review of the need for the patient to be admitted to the hospital and on the appropriateness of the length of the stay. Because of inadequate appropriations, PSRO's have generally been unable to undertake the review of the ancillary and outpatient services that hospitals provide, as required by existing law. PSRO studies and testimony before the committee have amply demonstrated the extent to which unnecessary or avoidable utilization occurs with respect to certain hospital practices that have not been subject to general across-the-board review, including: diagnostic tests routinely provided on admission without a physician's order; weekend elective admissions (i.e., Friday and Saturday admissions) to hospitals which are not equipped or staffed to provide needed diagnostic services on weekends; and preoperative stays for elective procedures of more than one day without justification for the additional days.

The bill directs PSRO's that are able to do so to give priority to reviewing these areas of relatively frequent overutilization to assure that payment is made under the public programs only when the routine tests and unusually long preoperative stays and weekend admissions for elective conditions are medically appropriate.

For example, as is now the case in some PSRO's, elective admissions for surgery that involve preoperative stays of more than one day would require specific PSRO approval in order to be reimbursable. Similarly, weekend admissions for elective conditions would be reim-

bursable only where the PSRO finds that the hospital is equipped and staffed to provide necessary services over the weekend.

The committee recognizes the need for additional funds for the PSRO program to engage in these reviews and expects that such funds will be made available.

Part C—Provisions Relating to Skilled Nursing Facilities, Intermediate Care Facilities and Home Health Care

SECTION 221—HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

The bill would permit medicare and medicaid reimbursement to be made for long-term care in small rural hospitals that use their beds interchangeably as either acute or long-term care beds, depending on need. Many rural hospitals are the only source of acute care in their communities and, as such, are a necessary and vital resource to the people they serve. Although many of these hospitals have recognized that the use of their acute care beds for needed long-term care services during periods of excess bed capacity would be desirable, current program participation and reimbursement requirements have discouraged these hospitals from doing so.

Under present law, a hospital-based skilled nursing facility (SNF) can participate in medicare and medicaid only if the facility is an identifiable, separate unit within the institution.

This requirement was developed to establish a separate cost center for purposes of program reimbursement and to facilitate the application of the different sets of program health and safety standards that are applicable to the two levels of care. However, it has proven to be administratively burdensome to many small hospitals. In addition, the identification of specific beds, staffing and other program requirements have not allowed sufficient flexibility in meeting episodic demand for acute beds—an important consideration when working with the small total bed complement characteristic of many rural hospitals.

The bill establishes a simplified cost reimbursement formula which would permit small rural hospitals to avoid the requirement for separate patient placement within the facility and separate cost finding.

Reimbursement for routine SNF services under medicare would be at the average rate per patient day paid for routine services during the previous calendar year under medicaid to hospital-based and freestanding SNFs located in the State in which the hospital is located. Reimbursement under medicaid would be at the rate paid to such SNFs and intermediate care facilities (ICFs) in the previous year. In the case of a State which does not participate in medicaid, reimbursement would be at the average rate per patient day paid to SNFs in that State by the medicare program. Reimbursement for ancillary services to swing-bed patients would be determined in the same manner as for hospital patients under present law.

Reimbursement under the new formula would be allowed in a hospital which (1) has less than 50 beds; (2) is located in a rural area; and (3) has been granted a certificate-of-need for the provision of long-term care services. The Secretary is also authorized to apply the new formula on a demonstration basis to hospitals of up to 100 beds provided they are otherwise qualified.

Since the general staffing pattern in small rural hospitals is relatively fixed due to minimum staffing requirements, there should be opportunities for providing needed long-term care services at little additional cost.

The committee emphasizes that the reimbursement method authorized by this section of the bill is optional, and hospitals may continue to elect to establish distinct part SNFs as provided for under existing law. Also, small rural hospitals that now maintain distinct-part SNFs as separate cost centers may switch to the simplified reimbursement procedure provided by the bill. It is not the intention of the committee that this provision prohibit States from continuing to use other approved reimbursement methods under State medicaid plans.

The bill provides that within 3 years after enactment the Secretary shall report to Congress concerning (1) the effect of this program on long-term care services; (2) whether the program should be continued; and (3) whether a similar provision should be applied to other hospitals where there is a shortage of long-term care beds, regardless of number of beds or geographic location.

SECTION 222—MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING FACILITIES (SNF'S) AND INTERMEDIATE CARE FACILITIES (ICF'S) INTERMEDIATE SANCTIONS

Under present law the State medicaid agency makes the decision as to whether a SNF or ICF applying to participate in the medicaid program only is qualified to participate in the program.

However, for a SNF participating in medicare only, or both medicare and medicaid, the Secretary makes the decision as to whether the facility is qualified to participate in the programs.

The bill would authorize the Secretary to validate State determinations on the eligibility of SNFs and ICFs under medicaid and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation. The bill provides for the Secretary to exercise this authority where he has cause to question the adequacy of the State's determinations.

Under current law, the sanction used to enforce requirements for participation in the medicare and medicaid programs is limited to decertification of a provider or supplier of services. In some instances this sanction has proven too severe and unwieldy to apply.

The bill provides the Secretary with the authority to impose intermediate sanctions, less severe than decertification, in those cases where a skilled nursing facility or intermediate care facility has been found to be out of compliance, but with the stipulation that they may only be used if the failure to comply does not jeopardize the health and safety of the patients. The intermediate sanctions could be applied before the provider has initiated any appeal. However, the facility could be afforded a reasonable period in which to correct the deficiencies. The intermediate sanctions could entail restricting the number and/or kinds of patients for whom reimbursement may be made to the facility, until the failure is corrected.

Facilities dissatisfied with the findings of the Secretary would be entitled to a hearing by the Secretary and to judicial review of the

Secretary's final decision following the hearing. Any intermediate sanctions would remain in effect during the period in which a hearing or judicial review is pending, unless otherwise ordered by the Secretary or by Court order.

Regulations implementing this provision are required to be issued by the Secretary not later than the first day of the sixth month following the month of enactment; this provision becomes effective on that same date.

SECTION 223—VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

The bill prohibits the Secretary of HEW from imposing numerical limits on the number of home visits which might be made by SNF or ICF patients under the medicaid program.

Until recently, an HEW policy, which has since been revoked, limited Federal payments for the cost of reserving beds in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) for medicaid patients temporarily away from the institution. The regulations permitted Federal funds to be used to reserve a bed for 15 days each time a patient was in a hospital for acute care. They also permitted Federal contributions for a total of 18 days during a 12-month period when patients were visiting their homes or other places for therapeutic reasons.

The Health Care Financing Administration has amended the regulations to remove all limitations on Federal funding of therapeutic absences. Currently, however, there are no requirements in existing law setting forth policies with respect to reserving beds in SNFs and ICFs.

The bill provides that visits outside of the SNF or ICF would not necessarily constitute conclusive proof that the individual is no longer in need of the services of the SNF or ICF. However, the length and frequency of visits must be considered, together with other evidence, when determining whether the individual is in need of the facility's services. The provision thus prohibits the Secretary from imposing numerical limits on the number of home visits which might be made by SNF or ICF patients. The committee believes that such matters should be left to professional medical judgment.

This provision would become effective on October 1, 1979.

SECTION 224—STUDY OF AVAILABILITY AND NEED FOR SKILLED NURSING FACILITY SERVICES UNDER MEDICARE AND MEDICAID

Under current law, skilled nursing facilities (SNFs) participating in either the medicare or the medicaid program are not required to participate in the other. In some States, there are a larger number of medicaid-only participating SNFs, and in other States the reverse is true. If a greater number of SNFs could be prompted to participate in both programs, a more adequate number of skilled nursing facilities would be available for medicare and medicaid beneficiaries.

The bill directs the Secretary of HEW to conduct a study of the availability and need for skilled nursing facility services under the medicare and medicaid programs. The study would investigate the desirability and feasibility of requiring facilities that wish to partici-

pate in one program to participate in both. The study would evaluate the impact of existing laws and regulations on SNFs and the extent to which these laws and regulations encourage SNFs to accept only medicare beneficiaries or only medicaid recipients. The study would also investigate possible changes in regulations and legislation which would result in encouraging a greater availability of skilled nursing services.

In developing the study, the Secretary would consult with professional organizations, health experts, private insurers, nursing home providers and consumers of skilled nursing facility services. A report on the Secretary's findings and recommendations would be due 6 months after the date of enactment.

SECTION 225—STUDY OF CRITERIA EMPLOYED FOR CLASSIFYING A FACILITY AS A SKILLED NURSING FACILITY

Under present law, a beneficiary must remain, for 60 consecutive days, out of an institution which is determined to be primarily engaged in providing skilled nursing care and related services in order to renew his medicare eligibility for additional days of hospital and skilled nursing facility benefits. The intent of these provisions was to permit beneficiaries to renew their benefit eligibility once they have ended a spell of illness (and, thus, for at least 60 days, no longer needed skilled nursing). However, beneficiaries in institutions that have been classified as being "primarily engaged in providing . . . skilled nursing care" and certain other skilled services, who have exhausted their benefits, are sometimes prevented from renewing their eligibility even though they actually receive little or no skilled care.

The bill directs the Secretary to review current procedures for applying the benefit-renewal criteria to make sure that they are not too restrictive. The Secretary would report his findings and conclusions to the Congress not later than December 31, 1980, together with any legislative recommendations he may wish to propose.

SECTION 226—PRESUMED COVERAGE PROVISIONS

The bill would repeal existing medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Protection against retroactive denials would continue to be afforded by general waiver of liability provision.

The 1972 social security amendments directed the Secretary to establish a minimum number of days of care in a skilled nursing facility or visits by a home health agency which would be "presumed" to be covered by type of patient diagnosis. This provision was enacted because skilled nursing facilities and home health agencies were experiencing a high rate of retroactive denials for services they provided on the assumption they would be covered by medicare.

A number of skilled nursing facilities and home health agencies have found the presumed coverage regulations confusing, often mistaking what are minimum days or visits covered as the maximum allowed. The regulations implementing this provision also have created complex administrative procedures to be followed by both the providers and the program. In addition, as a result of other, more effective,

waiver of liability provisions included in the same 1972 legislation, the presumed coverage provisions are rarely used. The committee notes that, according to HEW statistics, claims filed by skilled nursing facilities and home health agencies under the presumed coverage provision now represent far less than one-half of one percent of all claims for payment filed by these providers.

It is the committee's belief that the more general waiver of liability provision contained in section 1879 of the Social Security Act provides a more appropriate mechanism for addressing the type of situation intended to be covered under the presumed coverage provisions. As a result, the committee's bill repeals the presumed coverage provisions.

It is the committee's intention that since the general waiver of liability provision is to be used in all cases in this area, its rules are to be applied flexibly so as not to work undue hardship in cases which had been covered under the presumed coverage approach. In particular, it is intended that care be used in the application of rigid percentage limitations with respect to acceptable denial rates. This is particularly true in the case of those providers of service that have very small numbers of medicare beneficiaries where a denial in one or two cases might have the effect—through strict application of a percentage formula—of making them ineligible under the waiver of liability provision.

SECTION 227—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

Present law requires States participating in medicaid to pay skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) on a reasonable cost-related basis. This requirement, added by Section 249(a) of the Social Security Amendments of 1972, was designed to assure that payment rates would more closely reflect the reasonable costs necessary to provide nursing home services of adequate quality. Section 249(a) gives States the option of using medicaire's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

States have argued that the complex and long-delayed Federal regulations implementing the statutory requirement of section 249(a) have unduly restrained their administrative and fiscal discretion and that the Federal approval process has forced States to rely heavily on medicare principles of reimbursement. Neither of these consequences was intended when section 249(a) was enacted.

The committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs and that application of the reasonable cost reimbursement principles of the medicare program for long-term care facility services is not entirely satisfactory. These principles are inherently inflationary and contain no incentives for efficient performance.

The committee bill deletes the present language of section 1902 (a)(13)(E) of the act (which was added by section 249(a) of the 1972 legislation) and substitutes language which gives the States flexibility and discretion, subject to the statutory requirements of this section

and the existing requirements of section 1902 (a) (30) and section 1121 of the Act, to formulate their own methods and standards of payment.

Under the bill, States would be free to establish rates on a statewide or other geographic basis, a class basis, or an institution-by-institution basis, without reference to medicare principles of reimbursement. The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care. Under the bill, the State would be required to find, and make assurances satisfactory to the Secretary that the payment rates, taking into account projected economic conditions during the period for which the rates are set are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and standards. The State would also be required to assure the Secretary that it has provided for the filing by the facilities of uniform cost reports and for their periodic audit by the State.

The Congress expects that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements. It is expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.

In establishing rates, a State, at its option, could include incentive allowances designed to encourage cost containment through efficient performance, as well as incentives to attract investment where such investments would serve to alleviate demonstrated shortages of long-term care services. In addition, States would continue to have the option provided in current Federal Regulations to adjust rates downward for facilities with service deficiencies where facilities are classed by quality of service or level of care.

The Secretary would be expected to continue to apply current regulations which require that payments made under State plans do not exceed amounts which would be determined under the medicare principles of reimbursement. Since States would be free under the bill to establish payment rates without reference to medicare principles of reimbursement, the Secretary would only be expected to compare the average rates paid to SNFs participating in medicare with the average rates paid to SNFs participating in medicaid in applying this limitation.

SECTION 228—HOME HEALTH BENEFIT PROVISIONS

The bill includes several provisions related to home health services under medicare and medicaid, as described below.

Elimination of limitations.—The bill removes the provisions in existing law that limit medicare home health benefits to 100 visits per spell of illness under part A and 100 visits per year under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least 3 days before he can qualify for part A home health benefits.

Under present law, a beneficiary is eligible for 100 home health visits per spell of illness under part A of medicare following an in-

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patient stay in a hospital of at least 3 days. Beneficiaries are also eligible for 100 home health visits per calendar year under part B of medicare whether or not they have been hospitalized previously. By removing the numerical limit on home health visits and the 3-day prior hospitalization requirement, the committee believes that the home health benefit will become more widely available to eligible persons in need of such care. The provision would be effective with respect to services provided on or after July 1, 1980.

Plan of care.—Under current law, a plan of care must be established by a physician in order for a person to receive home health benefits under medicare and medicaid.

The bill requires that in establishing the plan of care, the plan must include a program for patient education aimed at achieving, to the extent possible, maximum independence from the need for care provided by other persons. The amendment would also allow physician assistants and nurse practitioners providing services in rural areas who are under the general supervision of a physician to establish plans of care for home health patients.

Reasonable costs.—The bill requires the Secretary of HEW, within six months after enactment, to establish guidelines for determining direct and indirect incurred costs of home health providers to serve as a basis for determining the reasonable cost of home health services. The guidelines would apply to specific line item costs of home health services.

Services in adult day care centers.—Some Medicare patients, though essentially homebound, are taken to an adult day care center as a means of enriching their lives. The Committee agreed to an amendment that would cover home health services provided in such centers on the same basis as when provided in the patient's home where the center: (1) is a nonprofit center which is eligible for funds under title XX of the Social Security Act, and (2) meets standards prescribed by the Secretary and applicable State and local health and safety requirements.

Homemaker-home health aides.—The Committee bill amends the reference to "home health aide" in the Medicare home health benefit coverage provisions. The proposed new reference, to "homemaker-home health aide", is more descriptive of the services performed by these personnel.

Reports on costs and utilization.—The bill requires the Secretary of HEW to monitor the costs of home health services and to report to the Congress within thirty days if such costs are increasing faster than the medical care services component of the Consumer Price Index. The report would include any recommendations for action, including legislative changes. In addition, the bill requires the Secretary to monitor and study the utilization of home health services and to issue an interim report to the Congress eighteen months after enactment and a final report to Congress three years after enactment.

Demonstration projects for utilization review.—Under medicare and medicaid, utilization review is required for hospitals and skilled nursing facilities but not for home health agencies. The bill requires the Secretary to establish demonstration projects to test, over a 2-year period, the effectiveness of utilization review committees in ensuring

the medical necessity, cost efficacy and appropriate use of home health services. The bill requires the Secretary to report to the Congress the findings concerning the effectiveness of these projects and any proposals for legislative action within six months after completion of the projects.

Part D—Provisions Relating to Medical and Other Health Services

SECTION 231—INCENTIVES FOR PHYSICIANS TO ACCEPT ASSIGNMENTS

The bill includes incentives for physicians to accept assignments by expediting payment of claims from "participating physicians"—i.e., physicians who accept assignment for all their medicare claims. It also authorizes five to ten pilot projects to experiment with ways of encouraging nonparticipating physicians to accept assignments.

Under current law, payments for physicians' services under medicare may be made directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. An assignment is an agreement between the physician and the medicare beneficiary under which the beneficiary "assigns" to the physician his rights to benefits for covered services included in the claim. In return the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. A physician may accept or refuse requests for assignments on a patient-by-patient, bill-by-bill basis.

The committee is concerned that assignment rates have been declining steadily. In calendar year 1978, the assignment rate for physicians other than those who normally bill through a hospital was 50.6 percent. In the case of claims for which assignment is not made, the elderly beneficiary becomes liable for that portion of the physician's charge which is in excess of the reasonable charge determined under the program. In 1978 medicare beneficiaries were responsible for an average charge of $16.94 for each unassigned claim; this was in addition to the required deductible and coinsurance amounts for which they were also liable.

The "participating" physician concept is employed by many Blue Shield plans. Under the bill, a "participating" physician is an M.D. or D.O. who voluntarily agrees to accept assignment and to accept the medicare reasonable charge, as payment in full for all services to all his medicare patients. Agreements would be cancellable or concluded on the basis of 30 days' notice. "Nonparticipating" physicians could continue to elect to use the assignment method of billing on a claim-by-claim basis, as under present law.

To expedite payment of claims from participating physicians, the bill provides that the Secretary would establish appropriate procedures and forms whereby: (1) such physicians may submit claims on one of various simplified bases and these claims would be given priority handling by the part B carrier; and (2) such physicians would obtain signed forms from their patients, effective for a period of time which the Secretary finds appropriate, making assignment for all services furnished to them and authorizing release of medical information needed to review the claim.

The committee is concerned that the increasing reluctance of physicians to accept assignment has resulted in a severe financial burden for many of the Nation's elderly. It also notes that a number of these individuals are unable to budget for these additional expenses because of uncertainty whether a physician will or will not accept assignment on a particular claim. The committee recognizes that the declining assignment rates are associated with a number of factors including administrative problems, payment delays, increases in the "reasonable charge" reductions, and general attitudes toward the program.

The bill therefore authorizes five to ten pilot projects to experiment with ways of encouraging physicians to accept assignment for all their medicare claims. Priority would be given to projects in States experiencing low assignment rates. Demonstrations may include but are not limited to: (1) payment of cost savings allowances to physicians who submit claims in a multiple listing format; (2) provision of incentive payments to physicians who agree to accept medicare's reasonable charge determination as payment in full; (3) payments at a rate of 100 percent of such charge where services are provided by a physician who has accepted assignment; and (4) use of prospective reimbursement to physicians on a periodic basis based on prior reimbursement rates. The results of the projects would be reported to Congress together with recommendations for increasing assignment rates. The committee anticipates that the Secretary will proceed expeditiously in carrying out these studies.

SECTION 232—USE OF APPROVED RELATIVE VALUE SCHEDULE

The bill authorizes the Secretary to approve the use of terminology systems and relative value schedules by physicians in billing medicare, medicaid, and for other purposes.

Third-party payors have frequently, in the past, employed relative value schedules (RVS) to determine payment rates for the many different services and procedures which physicians perform. These are lists of medical procedures and services which set forth their comparative numerical values. These relative numerical values take into account the relative time and effort which the physician expends in performing the specified procedures, consistent with their inherent difficulty. The experience, professional attainments and other characteristics which tend to reflect a physician's professional capacity and input will vary from physician to physician. The physician who sets his fees in accordance with a relative value schedule is expected to take these personal factors into account when a "conversion factor", the multiplier by which the relative values are translated into the dollar amounts he wishes to charge, is selected.

The resulting professional fees would be subject to the same tests of reasonableness as the charges of other physicians. While relative value schedules are useful mechanisms for assessing reasonableness of physicians' fees, they have also been cited by the FTC and the Department of Justice as being conducive to price fixing by the physician groups that have traditionally been responsible for their development.

The bill requires the Secretary to establish a system of procedural terminology, including a definition of terms, to provide a common language describing the various kinds of medical services which may be reimbursed under medicare, medicaid, and the maternal and child health program. The system would be developed by the Health Care Financing Administration with the advice of other large health care purchasers, representatives of professional groups and other interested parties. In developing the system, consideration would be given to the experience of third parties in using existing terminology systems in terms of implications for administrative and program costs, simplicity and lack of ambiguity, and the degree of acceptance and use. Interested parties would be given at least six months to comment on the proposed system and to recommend relative values for the designated procedures and services. A submission of such an RVS by an association of health practitioners to the Secretary in response to his request would not in itself constitute a violation of any consent decree by which such association had waived its right to make recommendations concerning fees. The proposed RVS could not be disclosed to any other party until it was made public by the Secretary.

The Health Care Financing Administration would review the submissions and recommend specific terminology and relative values for use under medicare. Such system could not be employed until: (1) interested parties had been given an opportunity to comment and such comments had been considered; (2) statistical analyses had been conducted assessing the economic impact of relative values on physicians in various specialties, geographic areas and types of practice and on the potential liability of the part B program; (3) it had been determined that the terms were clear and easy to evaluate in actual clinical situations and the assigned values generally reflected the relative time and effort required to perform various procedures and services, and (4) it had been determined that the system's use would enhance the administration of Federal health care financing programs. The approved system would be periodically reviewed by the Secretary and modified where appropriate. The system (as amended by any modification) could subsequently be used by other organizations or persons.

The committee intends that under this provision a common language will be established to describe the kinds of services that are covered under public and private health benefit plans and to provide for a more rational basis for evaluating the reasonableness of fees. Safeguards have been included to assure that the terminology and relative values clearly and accurately reflect the various kinds and levels of medical services provided. While physician groups may play an important role in their development, other factors must be considered prior to their approval and use.

SECTION 233—TEACHING PHYSICIANS

The bill extends the implementation date for section 227 of Public Law 92–603 for an additional year. It also provides an alternative reimbursement method for teaching hospitals which do not qualify for fee-for-service reimbursements for medical services under medicare.

Section 227 of Public Law 92–603, is intended to make it clear that, under medicare and medicaid, fees-for-service should be paid for medical care in teaching hospitals only where a bona fide private doctor-patient relationship exists. A further delay in implementation of this provision is needed to afford the Secretary of HEW additional time to consult with members of the medical education community and publish the necessary regulations. The bill therefore extends from October 1, 1978 to October 1, 1979, the implementation date of this section.

The committee notes that some teaching hospitals do not qualify for fee-for-service reimbursement for medical services under medicare because most or all of their nonmedicare patients generally do not pay fees for physicians' services. Such institutions can, under present law, elect to receive 100 percent cost reimbursement for physicians' services and house-staff costs.

The bill permits such hospitals to elect instead to have medicare pay reasonable charges, equal to 100% of the prevailing charge for similar services rendered in non-teaching hospitals for medical and surgical services furnished to the private patients (as defined by regulation) of teaching teams composed of a supervising physician, serving as the patients attending physician and physicians in training. To qualify under this provision, the hospitals and the physicians who practice in the hospitals must enter into agreements, that assure that reimbursement for physicians' services and for the stipends and graduate medical costs that the hospital incurs on behalf of the residents in-training and interns will be claimed only through reimbursement for the newly covered teaching-term services. The alternative payment method may be used under circumstances that assure that fees will be billed only where bona fide private patient-physician relationships exist.

The new benefit is designed to cover the services furnished by the team and its supervising physician in his capacity as the patient's attending physician. Reimbursement for the services of anesthesiologists, radiologists, pathologists and other physicians who provide ancillary or consultative services would not be affected.

SECTION 234—CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

Currently, medicare can reimburse the physician for his professional services in any setting. Also, the institutional costs of ambulatory surgery in a hospital outpatient department can be reimbursed. However, a charge for the use of special surgical facilities in a physician's private office or a free-standing surgical facility that is not hospital affiliated is not reimbursable.

Under the bill the physician performing certain listed surgical procedures in his office would be compensated for his special, surgical overhead through an all-inclusive rate if he accepts an assignment; there would be no deductible and coinsurance applied in such cases. Such procedures would include those which are often provided on an inpatient hospital basis but can, consistent with sound medical practice, be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician related services, including

normal pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure.

The list of procedures eligible for such reimbursement would be specified by the Secretary following consultation with the National Professional Standards Review Council and appropriate medical organizations including specialty groups. Subsequently, procedures could be added or deleted as experience dictated.

Normal review of such claims by Professional Standards Review Organizations, carriers and other present review mechanisms should work to safeguard against inappropriate or indiscriminate performance of procedures on an ambulatory basis.

Similarly, reimbursement would be provided for the use of the facilities in an ambulatory surgical center, without deductible or coinsurance, where the center accepts assignment. In the case of an ambulatory surgical center the payment could take the form of an all-inclusive rate, covering the facility overhead and physicians' fees or, alternatively, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the surgeon and to other physicians who provide services in connection with the procedure. The deductible and coinsurance would also be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments and other ambulatory surgical centers where the physicians accept assignment.

The overhead factor is expected to be calculated on a prospective basis (and periodically updated) utilizing sample survey and similar techniques to develop reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits). The committee does not intend that individual financial records be audited in order to determine a physician's or a center's specific overhead allowance. What is intended is a reasonable estimate of such costs of performing such procedures generally.

The committee expects that this provision will encourage performance of surgery in generally lower cost ambulatory settings, where appropriate, instead of the more expensive hospital inpatient setting. It anticipates that States will want to monitor the effectiveness of the new benefit with a view toward making similar modifications in their medicaid programs.

The committee is concerned that in some cases, a patient's stay in a hospital is unnecessarily protracted because it is less expensive to the medicare patient to receive diagnostic tests while in the hospital than prior to being admitted. The bill eliminates the financial incentives to unnecessarily utilize hospital care in cases where needed diagnostic services are provided in the hospital's outpatient department within the 7-day period prior to the patient's admission. The Secretary, in consultation with the National Professional Standards Review Council, would be required to specify those preoperative medical and other health services which could safely be performed on an outpatient as well as inpatient basis. A physician performing a listed service on an outpatient basis within the 7-day period prior to the patient's admission for surgery (to which the service relates) would receive reimbursement equal to 100 percent of medicare's reasonable charge if he agreed to accept such payment as payment in full.

SECTION 235—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. The committee notes that this has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, increases in prevailing charges are limited to levels justified by changes in the costs of practice and wage levels. The committee is concerned that the effect of present law is to further widen the dollar gap between prevailing charges in different localities.

The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Under existing law, medicare allows a new doctor to establish his customary charges at not greater than the 50th percentile of prevailing charges in the locality.

The bill would permit new physicians in localities which are designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual fee levels.

SECTION 236—DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

The bill prohibits the Secretary from routinely releasing medicare information, and provides that State agencies shall not be required to release medicaid information, relating to amounts paid to physicians under the respective programs, except as otherwise specifically required by Federal law.

Disclosure of physicians receiving large payments under medicare have served unjustifiably to embarrass physicians who serve a large number of elderly patients. The disclosures have, heretofore, also been characterized by a high degree of inaccuracy.

SECTION 237—PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

The bill amends current law to permit payment under medicare for the preparation by an allergist of a reasonable supply of antigens dispensed or administered under the supervision of another physician.

Current medicare law does not permit reimbursement for an antigen prepared by a physician unless he also administers it. However, it

is a common practice, especially in rural areas, for other dispensary practices to be followed—e.g., for a local doctor to refer a patient to an allergist who prepares a supply of antigens for the referring doctor's use.

The bill therefore permits payments under medicare for the preparation by an allergist of a reasonable supply of antigens dispensed or administered under the supervision of another physician. This would also include antigens dispensed in a rural health clinic, by a nurse practitioner or physician assistant, which is under the general supervision of a physician under an arrangement with such clinic.

SECTION 238—PAYMENT UNDER MEDICARE OF CERTAIN PHYSICIANS' FEES ON ACCOUNT OF SERVICES FURNISHED TO A DECEASED INDIVIDUAL

The bill would permit payment by medicare to be made to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill for care.

Under present law, medicare can pay a claim on behalf of a deceased beneficiary only where the physician accepts an assignment or where the bill has been paid. The committee notes that in cases where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

SECTION 239—PHYSICIAN TREATMENT PLAN FOR SPEECH PATHOLOGY

The bill would repeal the existing medicare requirement that a physician establish a detailed plan of treatment for speech pathology services.

The Social Security Amendments of 1972 provided for coverage of speech pathology services furnished on an outpatient basis in an organized setting such as a clinic, a rehabilitation agency, or a public health agency. Prior to 1972, outpatient speech pathology services were covered only when furnished by an approved hospital, skilled nursing facility, or home health agency. Present law requires that the patient be referred to the speech pathologist by a physician and that the physician establish and periodically review a plan of treatment which specifies the amount, duration and scope of services to be furnished.

Since speech pathology involves highly specialized knowledge and training, physicians generally do not specify in detail the services needed when referring a patient for such services. As a result, the committee believes that the requirement that the physician establish a plan of treatment should be eliminated so as to conform medicare law and related program policy to actual practice among the professions. The requirement for physician referral and periodic physician review of the plan of treatment would be retained.

SECTION 240—STUDY OF PAYMENT PROCEDURE FOR DURABLE MEDICAL EQUIPMENT

The bill requires the Secretary to conduct a study of present methods for determining payments for durable medical equipment

under medicare and to review and make recommendations on possible alternative reimbursement methods.

Under the medicare law, reimbursement for the rental or purchase of durable medical equipment is based largely on the supplier's customary charge for the item and on the prevailing charge for the equipment in the locality. Medicare has experienced problems with this method of reimbursement because of the lack of uniformity in suppliers' billing and charging practices; the different approaches medicare carriers follow in calculating allowances for medical equipment; and because equipment charges are not set in a broadly competitive marketplace. (HEW representatives have agreed to deal expeditiously with a further problem—differences in the level of services offered by different dealers—by providing for higher payments to be made to suppliers for delivery and other appropriate services.)

An additional problem has arisen as a result of the provision of present law which authorizes lump-sum payments by medicare for durable medical equipment where purchase would be more economical than rental. In these cases the patient is responsible for paying (in addition to any deductible and coinsurance amounts) any difference between the supplier's charge for the item and the medicare allowable charge. This difference can be substantial since the medicare allowable charge is based on charge levels as they existed from 12 to 24 months in the past.

The bill requires a study of the present methods of reimbursement for durable medical equipment and the problems associated with such methods. The study would also include an analysis of the feasibility of calculating (at least annually) allowable charges on a prospective basis which would take into account acquisition costs, appropriate overhead, and a reasonable margin of profit. The committee expects the Secretary to consult with representatives of the medical equipment suppliers in the course of this study. The Secretary would be required to submit a report on this study to the Congress within 12 months of enactment.

SECTION 241—DEDUCTIBLE NOT APPLICABLE TO EXPENSES FOR CERTAIN INDEPENDENT LABORATORY TESTS

The bill waives the $60 deductible in applying special laboratory billing procedures under medicare.

Legislation developed by the committee and enacted in 1972 (section 279 of Public Law 92–603) was designed to avoid the unreasonably high administrative costs that independent laboratories and the medicare program incur in the billing and processing of typically inexpensive diagnostic tests. That provision was intended to reduce these billing and processing costs by authorizing the Secretary of HEW to negotiate payment rates with individual laboratories which medicare would pay in full, without any need for the laboratory to bill the patient for the $60 deductible and 20 percent copayment amounts. The negotiated rates could be no higher than medicare would have paid (taking account of the billing and collection costs that the laboratory would have passed on to the program and reduced medicare administrative costs) in the absence of the new provision.

The new billing procedure was never utilized because, as a result of a drafting error, the $60 deductible was retained. Thus, since laboratories still have to bill patients for deductible amounts, and since medicare must still determine each patient's deductible status, the savings to laboratories and medicare cannot now be achieved.

The bill waives the $60 deductible in applying the special laboratory billing procedure, as was intended by section 279 of Public Law 92–603.

SECTION 242—DEDUCTIBLE NOT APPLICABLE TO EXPENSES FOR RURAL HEALTH CLINIC SERVICES

The bill waives the applicability of the medicare Part B $60 deductible with respect to services provided in rural health clinics.

Under present law, rural health clinics certified as providers under medicare must ascertain whether their medicare patients have satisfied the program's $60 deductible before they can determine what part of its charges are to be paid by the patient. This requirement is complicated, and it has disproportionately increased the billing and bookkeeping costs of these small facilities.

SECTION 243—COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES

The bill recognizes comprehensive outpatient rehabilitation facilities as "providers of services" under the medicare program if they are certified as meeting specific conditions of participation. Such rehabilitation centers could be public or private institutions primarily engaged in providing under medical direction, diagnostic, therapeutic, and restorative services to outpatients.

Under present law, medicare covers certain rehabilitation services in a variety of settings under various coverage provisions. Such services are included among the services that may be reimbursed on a charge basis as "incident to" the services of a physician. Outpatient physical therapy and outpatient speech pathology services are covered on a cost-related basis when furnished by a clinic, rehabilitation agency or public health agency; however, this coverage provision does not include occupational therapy and other rehabilitation services. Services furnished by an independently practicing physical therapist in the office setting are also covered, but there is an $80 annual limit on the amount medicare will pay for such services.

The bill authorizes coverage for a broad array of rehabilitation services when these are furnished on an outpatient basis in a coordinated fashion by a comprehensive outpatient rehabilitation facility.

Reimbursement to such facilities would be authorized under Part B of the program, based on the costs they incur in furnishing covered services, including: physicians' services, nursing care, physical therapy, occupational therapy, speech pathology, respiratory therapy, social and psychological services, prosthetic and orthotic devices, drugs and biologicals (which cannot be self-administered), supplies, appliances, equipment (including the purchase or rental of equipment), and certain other items and services necessary for the rehabilitation

of the patient. The bill thus permits reimbursement for rehabilitation services provided in a certified outpatient rehabilitation facility to be made on the same basis as these services are presently reimbursed if they are provided on an outpatient basis by a hospital.

SECTION 244—AMBULANCE SERVICE

The bill provides for medicare reimbursement for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care.

Medicare will now pay for ambulance services to the nearest participating institution with appropriate facilities where the use of other means of transportation is contraindicated by the individual's condition. The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. The individual physician who practices in a hospital is not a consideration.

Occasionally, the nearest hospital with appropriate facilities does not have a physician available to undertake the required specialized care. The present alternatives are to bring the physician to the patient—a possible misuse of physician time—or to transport the patient to the more distant facility at his own expense.

The committee also notes that in some areas of the country, particularly rural areas, radiation therapy and other specialized procedures are provided by a radiation facility that is not part of a hospital. In these areas patients who require transportation by ambulance—where other forms of transportation are medically contraindicated—to such a facility cannot qualify for medicare reimbursement.

The committee intends that the ambulance benefit also be extended to cover patients who require ambulance transportation to receive radiation therapy and other specialized procedures in areas where the treatment is not available in a hospital. Reimbursement for ambulance services to the outpatient facility should ordinarily be allowed only if it is the nearest available facility where the procedure is available, and only where the service in the facility is consistent with the State's health facilities planning efforts.

SECTION 245—COVERAGE UNDER MEDICARE OF CERTAIN DENTISTS' SERVICES

The bill extends the coverage of dental services under medicare to include those services performed by a doctor of dental medicine or dental surgery which he is legally authorized to perform in cases where the services would be covered if performed by a physician. The bill also would provide that payments would be made under medicare for inpatient hospital stays that are justified because of the severity of the patient's dental procedure or condition.

Under present law, medicare covers the services of dentists only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone. The law, therefore, excludes from coverage certain nonsurgical procedures which doctors of dental medicine and dental surgery (previously known as doctors of dentistry or dental or oral

surgery) are professionally trained and licensed to perform even though the same services are covered when performed by a physician. The bill would correct this discrepancy.

The committee also concluded that present coverage for inpatient hospital services related to certain noncovered dental procedures is inadequate. The test for medicare coverage of the inpatient services is the patient's underlying medical condition (e.g., history of heart failure). The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of the dental procedure alone requires hospitalization. Accordingly, the bill would provide for coverage of hospital stays where hospitalization is warranted either by the severity of the patient's condition or the dental procedure.

SECTION 246—COVERAGE UNDER MEDICARE OF OPTOMETRISTS' SERVICES WITH RESPECT TO APHAKIA

The bill authorizes medicare part B reimbursement to optometrists for covered services related to aphakia which are within the scope of licensed optometric practice. Certain diseases of the eye result in surgical removal of the lens. The resulting condition, i.e., absence of the lens of the eye, is known as aphakia. Eyeglasses (or contact lenses) serve as the prosthetic lens for the aphakic patient.

Current medicare law provides reimbursement for diagnosis and treatment of the diseases of the eye when such services are provided by physicians. Optometrists are reimbursed under the program only for dispensing services in connection with the actual fitting and provision of prosthetic lenses. Section 109 of Public Law 94–182 required HEW to conduct a study concerning the appropriateness of broadening the coverage of services that optometrists furnish to aphakic patients. In a report transmitted to the Congress on January 12, 1977, HEW recommended that those covered services related to aphakia and within the scope of optometric practice be reimbursable under part B of medicare when provided by optometrists. The bill incorporates this recommendation.

The committee noted that the HEW report recommended further study prior to any additional extension of part B coverage of optometric services. The committee expects that HEW will complete such study and report to the Congress within 12 months after enactment of the bill.

SECTION 247—CHIROPRACTIC SERVICES

The bill would modify the requirement for chiropractic coverage so that a "subluxation" could be demonstrated to exist through chiropractic clinical procedures other than an X-ray. Neither the X-ray, where utilized, nor any other clinical procedures used by the chiropractor would be reimbursed by medicare.

Under present law, medicare covers only those services of chiropractors which involve treatment of a subluxation of the spine (partial dislocation) by means of manual manipulation of the spine. The existence of a subluxation must be demonstrated by X-ray; however, the cost of the X-ray is not covered when performed by a chiropractor.

The X-ray requirement was intended to control costs by excluding from coverage cases in which a subluxation was not evident on an X-ray. The General Accounting Office has indicated that the extent to which X-rays play a part in claims denial is not known. Although chiropractors must have X-rays available upon request, the X-ray is actually reviewed by medicare carriers in only a small number of cases.

The committee believes that the requirement for an X-ray to demonstrate the subluxation of the spine is not an effective requirement, is possibly hazardous, and—since it is not paid for by the program—represents a significant cost to beneficiaries. Since chiropractors would not ordinarily take X-rays in every case to diagnose subluxation of the spine, the committee has concluded that it is inappropriate to require X-rays, with their accompanying radiation risks, for administrative purposes. The committee is also concerned that although the X-ray is currently required in all cases, the beneficiary must bear the cost of the X-ray.

For these reasons, the bill provides that the presence of subluxation could be demonstrated by procedures other than X-ray.

SECTION 248—TREATMENT OF PLANTAR WARTS

The bill eliminates the present medicare exclusion of services related to treatment of plantar warts.

Under present law, coverage for services related to rountine foot care—which is defined as "including the cutting and removal of corns, warts, or calluses, trimming of nails, and other routine hygienic care"—is specifically excluded.

Warts on the feet (often called plantar warts because they may appear on the plantar surface of the foot), are tumors caused by infectious viral agents. However, because of the routine foot care exclusion in present law, treatment for plantar warts is not a covered service, while the treatment of warts located elsewhere on the body is a covered service. The bill therefore eliminates the present medicare exclusion from coverage of services related to the treatment of plantar warts.

SECTION 249—LIMITATION ON REASONABLE COST AND REASONABLE CHARGE FOR OUTPATIENT SERVICES

The bill requires the newly established Health Facilities Cost Commission to give priority to the development of limitations on hospital outpatient and clinic costs. Further, the Secretary is required to issue regulations providing for the establishment of such limitations.

As a result of various limits placed by public agencies and others on inpatient hospital expenditures, some hospitals have sought to have a disproportionately large share of their total costs financed by the revenues from their outpatient departments. In addition, reimbursement to community health centers and similar freestanding clinics which are presently paid on a cost-related basis, have, according to the General Accounting Office, sometimes proved to be excessive.

The bill therefore requires the Health Facilities Cost Commission (established under Section 202 of this bill) to give immediate priority

to making a study and submitting recommendations to the Secretary with respect to setting limitations on costs or charges for outpatient services. Further, the Secretary is required to issue regulations establishing such limitations with respect to services provided on an outpatient basis by hospitals, community health centers, or clinics (other than rural health clinics) and by physicians using such facilities.

Part E—Miscellaneous Provisions

SECTION 251—CONFIDENTIALITY OF PSRO DATA

The bill provides for the confidentiality of certain PSRO information that identifies an individual patient, practitioner, provider (other than aggregated statistical information with respect to a given provider or providers), supplier, or reviewer.

In authorizing the Professional Standards Review Organization (PSRO) program in 1972, the Congress set forth principles, in section 1166 of the Social Security Act, that were to serve as the basis for regulations governing both the disclosure and the confidentiality of information acquired by PSRO's in the exercise of their duties.

Confidentiality is critical to the success of PSRO's because they rely on voluntary service by local physicians. Should all data acquired by PSRO's be disseminated without safeguards, recruitment of physicians to perform PSRO functions would become increasingly difficult. Moreover, the intent of peer review, as opposed to Government regulation, is to allow the profession to attempt to regulate itself with some degree of privacy and candor.

However, on April 25, 1978, the U.S. District Court for the District of Columbia held that a PSRO is an "agency" of the Federal Government for purposes of the Freedom of Information Act and is thus subject to the disclosure requirements of this later legislation. This decision, which is currently being appealed, would require that the data and information in control of the PSRO must be disclosed, on request, unless the particular information to be protected is specifically exempted from disclosure under the Freedom of Information Act. On September 25, 1979, the U.S. District Court for the District of Columbia ruled that none of the exemptions to the FOIA apply to PSRO's. Both decisions are being appealed. However, they are currently having an adverse impact on the PSRO program. The purpose of the bill is to limit the discretion of the Secretary in determining to whom disclosure may be made and to identify particular types of material to be withheld from the public (e.g., information which is not in the form of aggregate statistical data). In this manner the bill would establish that, assuming PSRO's are ultimately determined to be agencies under the Freedom of Information Act, PSRO data would be disclosed only under section 1166 of Title XI of the Social Security Act and would be protected under section 552(b)(3) of the Freedom of Information Act.

The bill therefore, provides for the confidentiality of PSRO information, which was not publically available at the time acquired, that identifies (by name or inference) an individual patient, practitioner, provider (other than aggregated statistical information with respect to providers), supplier, or reviewer. As under section 1166, as presently

worded, information may be disclosed to the extent necessary to carry out program purposes, to assist with the identification of fraudulent and abusive activities, and to assist in the conduct of health planning activities. The bill further requires the Secretary to issue regulations (which assure adequate protection of the rights and interests of patients, health care practitioners, and providers) which specify the cases and circumstances under which information may be disclosed to: the Secretary, General Accounting Office, claims payment agencies, public agencies responsible for monitoring or auditing claims, medical review boards for renal disease network areas, State and local public health officials, researchers and statistical agencies, courts, organizations providing specified services to the PSRO, other PSRO's, the statewide council, institutions or practitioners within the PSRO, agencies recognized by the Secretary as having licensing, accreditation, or certification functions, entities recognized by the Secretary as having monitoring functions with respect to the PSRO. No disclosure may be made under this subsection unless it is necessary to carry out the purposes of the PSRO program. The Committee intends, thereby, to significantly inform the discretion of the Secretary of HEW by establishing a list of agencies and persons to whom permissible disclosure may be made. In addition the regulations shall specify circumstances under which disclosure may be made to, or with the consent of, the individual identified in the records.

The bill would not limit disclosure of aggregate statistical information which identifies a provider, such as data which describe patient populations, the care and services given to patients, the objectively determined outcomes of such care and services, and determinations regarding the medical necessity of such care and services. To encourage effective peer review, some protection must be given to provider, such as specific information gathered in conducting sensitive and subjective one-time assessments of performance (e.g., medical care evaluation studies).

It should be noted that the Secretary of HEW in his regular review of PSRO performance can, and should under present law, evaluate the review activities—including practitioner profiles of practice—and thus safeguard against any general indiscriminate or willful action or inaction by a given PSRO with respect to practitioners.

SECTION 252—PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

The bill provides, except under certain specified circumstances, that reimbursement to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized where compensation or payments (in whole or part, in cash or kind) are based upon percentage arrangements.

Percentage arrangements can take several forms. For example, some involve business contracts for support services, such as computer and data processing, financial and management consulting, or the furnishing of equipment and supplies to providers of health services, such as hospitals. Charges for such services are subsequently incorporated into the cost base against which medicare and medicaid make their payment determinations.

The contracts for these support services specify that the remuneration to the suppliers of the services shall be based on a percentage of the gross or net billings of the health care facilities or of individual departments. Other examples involve landlords receiving a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the programs which may not reflect actual efforts expended or costs incurred.

The prohibition against percentage arrangements contained in this section of the bill would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis. It would also apply to management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization, or from the original provider or organization to the supplier or service agency.

The committee does not, however, intend this provision to interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the commission paid to a salesman. Further, the bill does not prohibit reimbursement for certain percentage arrangements such as a facility management contract where the Secretary finds that the arrangement contributes to efficient and economical operation.

For example, under some existing management contracts, the contractor receives both a percentage of operating expenses as a base management fee, and a share of the net revenues of the institution after all costs have been met. Where the contractor's percentage share of net revenues exceeds the percentage on which the base management fee is calculated, the contractor could have a strong incentive to contain operating expenses. Of course, under such circumstances, the reasonableness of the percentages applicable to the operating expenses would have to be considered in terms of comparison with the costs incurred in the management and/or operation of reasonably comparable facilities which do not utilize such contracts.

In the case of hospital-based physicians, on the other hand, the bill would permit recognition of percentage arrangements if the amount of reimbursement does not exceed an amount which would reasonably have been paid to the physician under relative value schedules (see explanation of sec. 232 for description) approved for this purpose by the Secretary. Under such an approved relative value schedule, the charges of a given physician would be subject to a test of reasonableness in terms of that physician's usual contribution of time and effort in the provision of the services for which he bills.

Percentage arrangements entered into by hospitals and hospital-based physicians before January 1, 1979, could be recognized subject to the same tests of reasonableness as were prescribed by regulations in effect on such date until such time as the hospital is able to unilaterally terminate such arrangement, or January 1, 1982, whichever is earlier.

The bill directs the Secretary to conduct a study of hospital-based physician reimbursement and the impact of alternative reimbursement

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methods on providers, patients, physicians, and third-party payers. He must submit his findings, together with legislative recommendations within two years of enactment.

The committee recommends that HEW adopt as its policy under existing law those provisions relating to the reimbursement of anesthesiologists' services which were included in S. 505, which contained the predecessor of this provision. That provision would provide that full fees could be paid to an anesthesiologist only where he personally performed all the professionally appropriate pre- and post-anesthetic services and carried out the most demanding procedures in connection with administration of the anesthesia for no more than two patients. Payments equal to one-half of the full fee for each patient could be made where the anesthesiologist personally directed other individuals in carrying out the most demanding procedures, provided the anesthesiologist personally performed the other pre- and post-anesthetic services and was responsible for no more than four patients during the course of anesthesia administration.

SECTION 253—REPEAL OF SECTION 1867

The bill terminates the Health Insurance Benefits Advisory Council.

The original 1965 medicare legislation provided for the establishment of the Health Insurance Benefits Advisory Council (HIBAC) under the new section 1867 of the act. This Council was to provide advice to the Secretary on matters of general policy with respect to the administration of medicare. The Social Security Amendments of 1972 modified the role of the Advisory Council so that its function would be that of offering suggestions for the consideration of the Secretary on matters of general policy in both the medicare and medicaid programs.

In view of the establishment of other advisory groups, and the Secretary's authority to establish ad hoc advisory bodies, the bill would terminate HIBAC.

SECTION 254—DEVELOPMENT OF UNIFORM CLAIMS FORMS FOR USE UNDER HEALTH CARE PROGRAMS

The committee bill requires HEW to adopt, to the extent feasible, standardized claims forms for medicare and medicaid within 2 years of enactment.

The committee notes with concern that the medicare and medicaid programs have added to the paperwork required of physicians, hospitals, skilled nursing facilities, and other health care organizations as a result of the proliferation of forms. For several years, HEW has been working to develop standardized claims forms that might be used by physicians and institutions in billing both medicare and medicaid. This effort has been carried out in conjunction with provider groups, including the American Medical Association, the American Hospital Association, and the American Dental Association. The National Association of Blue Cross-Blue Shield Plans and the Health Insurance Association of America also participated. Standardized physician benefits forms now have been developed and are being used by medicare,

medicaid and Blue Shield in several States. A promising uniform hospital benefit form has also been developed.

The committee bill requires the Secretary, within 2 years of enactment, to develop and require to be employed to the extent feasible, uniform claims that would be utilized in making payment for health services under medicare and medicaid. The committee intends that pretesting of such forms be conducted where necessary prior to their widespread application.

The uniform claims forms may vary in form and content but only to the extent clearly required. The committee recognizes that variances would occur in cases where simplified claims forms, such as multiple listing claims forms, are utilized in accordance with the provision of this bill which provides incentives for physicians to accept assignment.

The bill requires the Secretary to use the claims forms developed for purposes of medicare and medicaid for other programs over which he has administrative responsibility if he determines that such use is in the interest of effective administration of such programs.

The committee bill requires the Secretary, in carrying out the requirements of this section, to consult with those charged with the administration of other Federal health care programs, with other organizations that pay for health care, and with providers of health services to facilitate and encourage maximum use by other programs of the uniform claims forms. The bill further requires the Secretary to report to the Congress within 24 months of enactment on: (1) what actions he will take pursuant to this section; (2) the degree of success in encouraging third parties generally to adopt uniform claims forms, and (3) his recommendations for legislative and other changes needed to maximize the use of such forms.

SECTION 255—MEDICARE LIABILITY WHERE PAYMENTS CAN BE MADE UNDER LIABILITY INSURANCE

The bill provides that medicare would not be the payor of first resort in cases where the patient is involved in an accident and his care can be paid for under liability insurance of the individual who was at fault or under a no-fault insurance plan.

Under present law, medicare is ordinarily the payor of first resort except in certain cases, e.g., where the patient has no legal obligation to pay, or where workmen's compensation is responsible for payment for the patient's care.

The bill provides that where the medicare patient is involved in an accident and his care can be paid for under the insurance of the individual who was at fault (or under a no-fault plan), medicare would have residual and not primary liability. Under this provision, medicare would pay for the patient's care in the usual manner and then seek to be reimbursed by private insurance after, and to the extent that, liability has been determined. The bill leaves to the discretion of the Secretary an evaluation of the probability of recovery and the minimum amounts estimated as recoverable, so as to avoid the administrative cost and effort of pursuing minor recoveries or situations where there is little likelihood of ultimate recovery.

SECTION 256—JUDICIAL DISTRICT IN WHICH PROVIDERS MAY OBTAIN JUDICIAL REVIEW

The bill permits Federal judicial review of adverse decisions of the Provider Reimbursement Review Board involving actions brought jointly by several providers of medicare part A services to be taken in the district where the "principal party" for the group is located.

Under existing law an individual provider of medicare part A services may have an adverse decision of the Provider Reimbursement Review Board reviewed by the U.S. district court for the district in which the provider is located, or alternatively in the U.S. district court for the District of Columbia. However, because of the language of the current statute, judicial review of these decisions brought jointly by several providers may be taken only in the U.S. district court for the District of Columbia. The bill would permit actions brought jointly by several providers to be taken in the district where the "principal party" is located. The committee expects that in defining "principal party," the Secretary's regulations would establish objective criteria that would prevent "forum shopping." The committee expects that, ordinarily, the principal party to a suit would be the providers' headquarters office, if the parties are commonly owned or, in the case of independent providers, the party with the most money at stake.

SECTION 257—RESOURCES OF MEDICAID APPLICANT

The bill permits States to deny medical assistance to any aged, blind, or disabled person (including individuals who are not "categorically ineligible") who has given away assets in order to meet the medicaid eligibility requirements (or has "sold" such assets for less than their fair market value).

Under present law, States must provide medical assistance eligibility to recipients of aid to families with dependent children (AFDC) and to recipients of supplemental security income (SSI). In the case of SSI recipients, States have the option of making all SSI recipients eligible for medicaid or of limiting eligibility to those who met the State standards under the former State programs of aid to the aged, blind, and disabled as in effect in 1972. States may deny eligibility for AFDC to persons who give away assets in order to meet the resources limits of that program and States which had such restrictions in their former programs for the aged, blind, and disabled in 1972 may continue to apply them in determining medicaid eligibility (but only if they are among the States that have elected to continue using those 1972 standards). However, States which have elected to make all SSI recipients eligible for medicaid do not have this option. In such States an individual who is on the SSI rolls must be included in the medicaid program even if he became an SSI recipient only by giving away property (or by selling it for far less than its true value).

Where an individual with significant assets is faced with the prospect of substantial medical expenses—particularly in cases where a prolonged period of institutionalization may be needed—present law may provide a strong incentive for him to give those assets away to a friend or relative so as to qualify for medicaid immediately. To the extent that this happens, the costs of the program are increased since

medical expenses which could be met from the individual's assets are instead being paid for by public funds.

The bill would allow States the option of denying or limiting eligibility in this type of situation. If a State chooses to make use of this provision, an aged, blind, or disabled person would be considered (for purposes of medicaid eligibility) to still possess a disposed-of asset for a period of 12 months if he gave it away in order to become eligible for medicaid. (In the case of an individual who sells an asset far less than its value, he will be considered for 12 months to have an asset worth the difference between the sale price and the fair market value.)

The gift or sale for less than value of an asset will, under the provisions of the bill, be presumed to have been for purposes of establishing medicaid eligibility unless the individual submits adequate evidence to rebut that presumption.

The committee intends that this authority would be administered by the States even though other elements of medicaid eligibility may be determined by the Social Security Administration under the agreements entered into pursuant to section 1634 of the Social Security Act. It is expected, however, that the Social Security Administration would agree to reasonable State requests for referral of SSI applicants to appropriate State or county agencies for determination of this additional eligibility factor.

The committee emphasizes that the provision is aimed at abusive situations where assets are sold for substantially less than their fair market value. It is not intended, for example, that the provision would be used to call into question the sale of a piece of land for $1,000 or $2,000 in which the sale price may fall short of the agency's estimate of fair market value by $100 or $200.

SECTION 258—PAYMENT FOR LABORATORY SERVICES AND CERTAIN MEDICAL DEVICES UNDER MEDICAID

The bill allows a State to purchase laboratory services (for a 3-year experimental period) and medical devices for its medicaid population through competitive bidding or other arrangements.

The committee notes that the Comptroller General, in a July 1, 1978, report to the Congress, recommended that States be given greater latitude in paying for independent laboratory services under medicaid. States have been restrained in adopting cost-saving contract bidding and negotiated rates with laboratories by an interpretation of the present "freedom of choice" provision. That provision, a Finance Committee amendment in 1967, was intended to permit medicaid recipients to choose from among any qualified doctors, pharmacies, etc. It was not intended to apply to the types of services, such as laboratory services, which the patient ordinarily does not choose.

Similarly, judicial interpretation of the "freedom of choice" provision has hampered cost-saving arrangements by States for the purchase under medicaid of medical devices (such as eyeglasses, hearing aids and wheelchairs) even though these items often do not vary in quality from supplier to supplier.

The bill therefore allows a State to purchase laboratory services for a 3-year experimental period, and medical devices for its medicaid

population through competitive bidding or other arrangements, such as negotiated rates. Under this provision, services may be purchased only: (1) from laboratories meeting appropriate health and safety standards; (2) where no more than 75 percent of the charges for such services are for services provided to medicare and medicaid patients; and (3) if the laboratories charge the medicaid program at rates that do not exceed the lowest amount charged to others for similar tests.

SECTION 259—AUTHORITY FOR CERTAIN STATES TO BUY—IN COVERAGE UNDER PART B OF MEDICARE FOR CERTAIN MEDICAID RECIPIENTS

The bill gives States which do not currently have a "buy-in" agreement with medicare an additional 12 months to enter into such arrangements.

The medicare law gave States until January 1, 1970, to request enrollment of their medicaid eligible beneficiaries in part B of the medicare program. States that entered into these so-called "buy-in" agreements pay the part B premiums for the public assistance enrollees. The "buy-in" provision was designed to encourage the highest possible participation of the elderly in the part B program. Alaska, Louisiana, Michigan, Oregon, Puerto Rico, and Wyoming did not make timely arrangements to enroll their medicaid eligible beneficiaries in the part B program.

The bill gives the States that wish to do so an additional period of 12 months in which they could elect to make the necessary coverage arrangements.

SECTION 260—EXTENSION OF PERIOD FOR FUNDING OF STATE MEDICAID FRAUD CONTROL UNITS

The bill extends for 2 years (until October 1, 1982) the period when increased Federal matching is available for funding of State medicaid fraud control units.

Section 17 of Public Law 95–142 provided 90 percent Federal matching in fiscal years 1978–1980 for the costs incurred in the establishment and operation (including the training of personnel) of State fraud control units. The increased matching is subject to a quarterly limitation of the higher of $125,000 or one-quarter of 1 percent of total medicaid expenditures in such State in the previous quarter. This section is intended to encourage States to establish effective investigative units on the State level.

Some States have experienced delays in establishing State fraud control units and have therefore been unable to fully avail themselves of the increased Federal matching authorized under the law.

The bill extends for two years (until October 1, 1982) the period when 90 percent Federal matching is available for the funding of State medicaid fraud control units. No State may receive such matching for longer than 3 years.

SECTION 261—MEDICAID PAYMENTS TO STATES

The bill provides that Federal medicaid funds may not be drawn upon until they are actually needed by the State to pay providers and practitioners.

Present Federal policies permit States to draw on Federal medicaid funds before they are actually needed to pay bills. During the period between the time when the Federal funds are drawn by the State and the time when they are disbursed, about 12 days on the average, the funds can draw interest which accrues to the State. HEW has proposed that the gap should be eliminated in fiscal year 1980 in 10 States, producing a one-time saving of $240 million for medicaid.

The Committee agreed to extend the new "checks paid" policy to all States before the end of fiscal year 1980. In States where a modification of State law is needed to implement this change, the effective date would be deferred until the beginning of the first calendar quarter that begins after the close of the next regular session of the State legislature.

SECTION 262—NOTIFICATION TO STATE OFFICIALS

The bill provides, under certain circumstances, for notification of the Governor and appropriate committee chairmen in a State legislature of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments affecting programs authorized under the Social Security Act.

The committee has become aware of instances where the Governors and chairmen of the appropriate legislative and appropriation committees in State legislatures have not been informed on a timely basis of deficiencies or potential compliance issues involving Federal-State programs authorized under the Social Security Act.

The committee bill provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under programs authorized under the act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the affected program.

SECTION 263—WAIVER OF HUMAN EXPERIMENTATION PROVISION FOR MEDICARE AND MEDICAID

The bill waives requirements of the human experimentation statute which may otherwise be held applicable for purposes of medicare and medicaid.

Under current law, State medicaid programs may impose nominal cost-sharing requirements on medicaid eligibles. One State's cost-sharing experiment was challenged as a violation of regulations implementing the human experimentation statute. The challenge would effectively prevent any cost-sharing experiments under the medicaid program, and could seriously hinder other medicaid and medicare cost control efforts.

The bill waives the requirements of the human experimentation statute which may otherwise be held applicable for purposes of medicare and medicaid. For example, the bill waives such requirements with respect to experimentation involving coverage, copayment, deductibles or other limitations on payments for services. The bill further provides that the Secretary, in reviewing any application for

any experimental, pilot or demonstration project pursuant to the Social Security Act, would take into consideration the human experimentation law and regulations in making his decision on whether to approve the application.

The committee intends that the provision would apply only to medicare and medicaid reimbursement and administrative activities not designed to directly experiment with the actual diagnosis or treatment of patients.

SECTION 264—DISCLOSURE OF MEDICAID INFORMATION

Present law provides in part that State medicaid plans include safeguards which prevent disclosure of the name or address of applicants or recipients to any committee or a lgislative body. HEW regulations include Federal, State, or local committees or legislative bodies under this provision. Under their guidelines, HEW exempts audit committees from this exclusion. Several States, however, do not honor the HEW exemption.

The Committee amendment would modify this section of the act to clarify that any Governmental agency (including any legislative body or component or instrumentality thereof) authorized by law to conduct an audit or similar activity in connection with the administration of the medicaid program is not included in the prohibition.

An amendment making similar changes with respect to the AFDC program and title XX were approved by the committee as part of H.R. 3236, the proposed Social Security Disability Amendments of 1979.

SECTION 265—DEMONSTRATION PROJECTS FOR TRAINING AND EMPLOYMENT OF AFDC RECIPIENTS AS HOMEMAKERS AND HOME HEALTH AIDES

The bill provides for demonstration programs in up to 12 States to formally train AFDC recipients as homemaker-home health aides. These individuals could then be employed by public and nonprofit private agencies to provide supportive services to people, primarily the aged and disabled, who would reasonably be expected to require institutional care in the absence of these services.

The bill is designed to deal with three major problems in the Nation's health and welfare programs, namely the need to provide alternative support services for individuals who would otherwise require institutionalization, to assist AFDC recipients to develop a marketable skill which will enable them to get off the welfare rolls, and to stem the increases in Federal and State costs for medicaid and welfare programs.

The bill establishes a means whereby many thousands of older and disabled people will be assisted in remaining at home rather than being moved into high-cost nursing homes and intermediate care facilities. It is estimated that as many as 40 percent or more of those in institutions do not necessarily have to be there—and would not be there if proper alternative supportive services were available. Most would prefer to live in familiar surroundings in which they can retain their sense of independence and dignity. The bill encourages the availability

of support services by taking persons now on the welfare rolls, formally training them as homemakers and home health aides, and using them to provide supportive services.

The committee expects that the large majority of these trained people will ultimately be removed from the welfare rolls because they will have become gainfully and usefully employed members of the health professions. Properly implemented, enormous savings in medicaid and welfare costs should result as people leave the welfare rolls and others are kept out of high-cost nursing homes and other long-term care facilities.

The bill authorizes the Secretary of HEW to enter into agreements with up to 12 States, selected at his discretion, for the purpose of conducting demonstration projects for the training and employment of AFDC recipients as homemakers or home health aides. The committee intends that priority be given to those States which have demonstrated active interest and effort in supporting the concept and in developing and encouraging this proposal. Full responsibility for the program would be given to the State health services agency (which may be the State medicaid agency) designated by the Governor. This agency would have to coordinate its activities, to the maximum extent feasible, with other State agencies having related responsibilities.

The committee expects that the Secretary will assign responsibility for implementation of this program to the Health Care Financing Administration as the agency responsible for the medicaid program.

The committee emphasizes that the program is completely voluntary; an AFDC recipient is under no obligation to enroll and does not risk loss of AFDC funds by refusing to participate. Persons eligible for training and employment would be only those who were continuously on the AFDC rolls for the 90-day period preceding application. Those who enter a training program would be considered to be participating in a work incentive program authorized under part C of title IV of the Social Security Act. During the first year such individual is employed under this program, he or she shall continue to retain medicaid eligibility and any eligibility he had prior to entering the training program for social and supportive services provided under part A of title IV. The individual will be paid at a level comparable to the prevailing wage level in the area for similar work. Federal funding will not be available for the employment of any eligible participant under the project after such participant has been employed for a 3-year period. After that period, the committee expects the individual to be able to obtain employment as an allied health worker.

The bill requires a State participating in a demonstration project to establish a formal training program, which is expected to be 10 to 12 weeks in duration. It is anticipated that the Secretary will assist States in developing the program where requested. The Secretary must approve the program as adequate to prepare eligible participants to provide part time and intermittent homemaker-home health aide services to individuals, primarily the aged and disabled, who would, in their absence, be reasonably anticipated to require institutional care. The State shall provide for the full-time employment of those who have successfully completed the training program with one

or more public agencies or by contract with nonprofit private agencies. The numbers of people in a State eligible for training and employment would be limited only by their ability to be trained and employed as well as by the number of those in need of home health and homemaker services. Thus, to the extent that a State can demonstrate increased capacity to train and utilize people, the numbers authorized in that State may be modified. The Secretary is expected to establish safeguards to assure that the program, as well as those trained and employed, are not exploited. Such safeguards should include assurances that a nonprofit agency seeking to employ those trained under the program is a recognized bona fide nonprofit entity and not a pro forma nonprofit mechanism.

The committee bill provides that persons eligible to receive homemaker-home health aide services are the aged, disabled, or others, such as the retarded, who are in need of such services. They must be those for whom such services are not reasonably and actually available and who would otherwise reasonably be anticipated to require institutional care within six months. Participating States would be required to provide for independent professional review to assure that services are provided to individuals actually needing them.

The committee bill extends eligibility for services to individuals whose income is less than 200 percent of the State's need standard under the AFDC program for households of the same size. It is expected that the large majority of medicare beneficiaries would, because of this income standard, be potentially eligible for these homemaker and home health aide services. However, while medicare program costs should be moderated as a result, these services, unless otherwise qualified for reimbursement, would not be a regular medicare benefit. The eligibility level has been established above the State's need standard because of the high probability that an individual, even with income somewhat above this standard, would become a medicaid recipient when he required skilled nursing home or intermediate care. States may also make the services of those home health aides and homemakers available to individuals with incomes above these limits; in such cases fees would be charged on a sliding scale basis.

The committee bill specifies that the type of services included as homemaker-home health aide services includes part time or intermittent: personal care, such as bathing, grooming, and toilet care; assisting patients having limited mobility; feeding and diet assistance; home management, housekeeping, and shopping; family planning services; and simple procedures for identifying potential health problems. The committee emphasizes that authorized services do not include any service performed in an institution or any services provided under circumstances where institutionalization would be substantially more efficient as a means of providing such services. It further notes that those trained under this program are not intended to be a reservoir of subsidized labor for hospitals. However, public and nonprofit hospitals might employ these people as outreach workers to facilitate timely discharge of hospitalized patients. Further, after they leave this program these individuals may subsequently be employed on a nonsubsidized regular basis, as occurred in New Mexico which pioneered this type of program.

The committee bill provides 90-percent Federal matching for the reasonable costs (less any related fees collected) of conducting the demonstration projects. Such amounts would be paid under the State's medicaid program. The committee anticipates no net cost since the reduction in medicaid costs resulting from the prevention or postponement of expensive care in institutions should more than offset the costs of training and provision of home health aide—homemaker services. It is anticipated that hospital stays may also be shortened—or even avoided—because of the availability of these services. The welfare burden should be eased to the extent that those trained ultimately find regular employment in the health care field—outside of this program.

The bill limits demonstration projects to a maximum of 4 years plus an additional period up to 6 months for planning and development and a similar period for final evaluation and reporting. The Secretary is required to submit annual evaluation reports to the Congress and a final report not more than 6 months after he has received the final reports from all the participating States.

Consistent with responsible administration, the committee expects that the Secretary will act expeditiously in implementing this program with a minimum of regulatory delay and a maximum of formal and informal cooperative effort with the States which have demonstrated interest. In the interest of expeditious and effective implementation of the program, the Secretary is authorized to waive formal solicitation and approval requirements.

SECTION 266—GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

This section of the bill is identical (except for effective dates) to an amendment approved by the Senate in 1972 and 1978.

The bill authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) institutions of higher learning. These grants are to assist institutions in the training of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and providing needed services for children and young adults suffering from such diseases.

SECTION 267—ADMINISTRATOR OF HEALTH CARE FINANCING ADMINISTRATION

The bill provides that the Administrator of the Health Care Financing Administration would be appointed by the President with the advice and consent of the Senate. The provision would apply to individuals appointed to the position after the date of enactment.

The Health Care Financing Administration (HCFA) is the agency in the Department of Health, Education, and Welfare responsible for administration, coordination, and policymaking for the medicare and medicaid programs. It was established by the Administration in early 1977 in order to provide the means for the orderly consolidation and coordination of these two major health programs. Consistent with these objectives, the activities and operations for both of these health care programs were merged in early 1979.

The Administrator of this agency should be an individual experienced and knowledgeable in health care and health care financing with full awareness of the complexity of the issues involved. The Administrator of the Social and Rehabilitation Service (an office now terminated) required appointment by the President and confirmation by the Senate primarily because of his responsibility for medicaid. The comparable position of the Commissioner of Social Security requires Presidential appointment and Senate confirmation.

SECTION 268—PSRO PARTICIPATION BY CERTAIN PRACTITIONERS

The bill requires local Professional Standards Review Organizations (PSRO's) to involve health care practitioners who hold independent hospital admitting privileges in the review of care ordered or rendered by these practitioners.

Under present law, membership in a professional standards review organization is limited to licensed doctors of medicine or osteopathy engaged in the practice of medicine or surgery in the organization's area. This membership requirement is based on the premise that only physicians are qualified to judge whether services ordered by other physicians, particularly in a hospital setting, are medically necessary. Moreover, to assure the effective review of hospital services, the law requires that PSRO physicians engaged in the review of the medical necessity for hospital care must be active hospital staff members. However, the committee notes that the provision of health care services furnished in a hospital setting may involve orders by independent health professionals other than physicians; for example, dentists and podiatrists. Since such health professionals hold hospital admitting privileges in many jurisdictions and are ordering services for which payment may be made under medicare and medicaid, the committee believes it is appropriate to provide the opportunity for such professionals to participate in the evaluation of these services.

The bill therefore requires local PSRO's to formally involve health care practitioners who hold independent hospital admitting privileges in the review of institutional services provided by such persons. The committee notes however that these practitioners would not be members of the PSRO. Further, the bill retains the requirement of existing law that only doctors of medicine or osteopathy may make final determinations with respect to the services performed by other M.D.'s and D.O.'s.

SECTION 269—NONPHYSICIAN MEMBERSHIP ON NATIONAL PROFESSIONAL STANDARDS REVIEW COUNCIL

The bill expands the membership of the National Professional Standards Review Council to include a doctor of dental surgery or dental medicine and a registered nurse.

Under present law, membership on the National Council, which advises the Secretary on policy and administrative matters relating to the PSRO program, is limited to doctors of medicine and osteopathy. The committee believes, however, that since the National Council is responsible for providing policy and administrative advice on

all services covered under medicare and medicaid including services furnished by dentists and nurses, such a limitation on membership moderates, to a certain extent, the effective performance of the Council's function. The delivery of high-quality health care is dependent upon the coordination of a multiplicity of services. While the physician's part in this process is crucial, it is recognized that he must often consult with and rely upon the professional judgments of nurses and dentists. In light of the important role played by these health professionals, particularly nurses in the review process, the committee believes there is a need to strengthen their participation in the PSRO program.

Recognition of registered nurses is warranted because they represent the largest health care discipline in the Nation. The potential for nurses to affect the overall quality and use of health services is probably greater than that of any single health professional group other than physicians.

III. Budgetary Impact of the Bill

In compliance with paragraph 6(a) of Rule XXVII of the Standing Rules of the Senate and sections 308 and 403 of the Congressional Budget Act, the following statements are made relative to the costs and budgetary impact of the bill.

The committee proposes to meet the requirements of the second concurrent resolution on the budget for fiscal 1980 in the manner outlined in the budget allocation report submitted by the committee to the Senate on November 29, 1979 (Senate Rept. No. 96–432). In the Health function of the budget, the committee has indicated in that report that it will recommend legislation reducing Federal spending for 1980 by a net $0.7 billion. The committee has previously reported legislation (S. 1204) related to the establishment of a Child Health Assessment Program (CHAP) and to medicaid matching for the territories. That legislation, as reported and with a modification which has been agreed to by the Committee, will increase Federal outlays by $28 million in fiscal year 1980. H.R. 934 as indicated below will reduce Federal spending in fiscal 1980 by $699 million. The impact of these two bills is, therefore, consistent with the health category savings of $0.7 billion in the allocation report.

COMMITTEE ESTIMATES

ESTIMATES BY THE COMMITTEE OF THE COSTS AND SAVINGS OF THE BILL FOR FISCAL YEARS 1980–84

COMMITTEE ESTIMATES OF THE COST IMPACT OF THE BILL

[In millions of dollars]

Provision	Cost impact in fiscal year[1]					
	1980	1981	1982	1983	1984	5-yr total
Sec. 101: Tax relief for Brian and Vera W. Hall	0	0	0	0	0	0
Sec. 202: Criteria for determining reasonable cost of hospital services	.6	−200.0	−950.0	−1,400.0	−2,050.0	−4,600.0
Sec. 203: Payments to promote closing and conversion of underutilized facilities	0	−1.8	−8.9	−23.6	−43.7	−78.0
Sec. 204: Federal participation in capital expenditures	0	0	0	0	0	0
Sec. 205: Rate of return on net equity for for-profit hospitals	3.2	50.5	59.1	68.5	78.8	260.1
Sec. 206: Coordinated audits under the Social Security Act	−17.0	−37.0	−40.1	−43.2	−46.7	−184.0
Sec. 208: Flexibility in application of standards to rural hospitals	0	0	0	0	0	0
Sec. 209: Certification and utilization review by podiatrists	0	0	0	0	0	0
Sec. 210: Apportionment of provider costs	−183.0	−209.7	−241.8	−278.8	−321.2	−1,234.5
Sec. 211: Reimbursement of inappropriate inpatient hospital services	−100.0	−150.0	−200.0	−250.0	−300.0	−1,000.0
Sec. 212: Conversion to long-term care facility	6.0	30.0	24.0	0	0	60.0
Sec. 213: PSRO review of hospital admissions, routine testing and preoperative stays	−125.0	−150.0	−200.0	−250.0	−300.0	−1,025.0
Sec. 221: Hospital providers of long-term care services	0	0	0	0	0	0
Sec. 222: Medicaid certification and approval of skilled nursing and intermediate care facilities; intermediate sanctions	0	0	0	0	0	0
Sec. 223: Visits away from institution by patients of skilled nursing or intermediate care facility	0	0	0	0	0	0
Sec. 224: Study of availability and need for skilled nursing facility services under medicare and medicaid	0	0	0	0	0	0
Sec. 225: Study of criteria employed for classifying a facility as a skilled nursing facility	0	0	0	0	0	0

COMMITTEE ESTIMATES

ESTIMATES BY THE COMMITTEE OF THE COSTS AND SAVINGS OF THE BILL FOR FISCAL YEARS 1980–84

COMMITTEE ESTIMATES OF THE COST IMPACT OF THE BILL

[In millions of dollars]

Provision	Cost impact in fiscal year[1]					
	1980	1981	1982	1983	1984	5-yr total
Sec. 226: Presumed coverage provisions	0	0	0	0	0	0
Sec. 227: Reimbursement rates under medicaid for skilled nursing and intermediate care facilities	0	0	0	0	0	0
Sec. 228: Home health benefit provisions	3.3	16.0	18.7	22.3	25.4	85.7
Sec. 231: Agreements with physicians to accept assignments	0	0	0	0	0	0
Sec. 232: Use of approved relative value schedule	0	0	0	0	0	0
Sec. 233: Teaching physicians	0	0	0	0	0	0
Sec. 234: Certain surgical procedures performed on an ambulatory basis	—6.2	—11.3	—24.7	—57.9	—101.3	—201.4
Sec. 235: Criteria for determing reasonable charge of physicians' services	0	0	0	0	0	0
Sec. 236: Disclosure of aggregate payments to physicians	0	0	0	0	0	0
Sec. 237: Payment for certain antigens under pt. B of medicare	.1	.2	.2	.3	.3	1.1
Sec. 238: Payment under medicare of certain physicians' fees on account of services provided to a deceased individual	0	0	0	0	0	0
Sec. 239: Physician's treatment plan for speech pathology	0	0	0	0	0	0
Sec. 240: Study of payment procedure for durable medical equipment	0	0	0	0	0	0
Sec. 241: Deductible not applicable to expenses for certain independent laboratory tests	0	0	0	0	0	0
Sec. 242: Deductible not applicable to expenses for rural health clinic services	0	0	0	0	0	0
Sec. 243: Comprehensive outpatient rehabilitation services	1.5	11.0	12.8	14.7	16.9	56.9
Sec. 244: Ambulance services	.5	1.1	1.3	1.5	1.7	6.1
Sec. 245: Coverage under medicare of certain dentists' services	3.5	16.4	19.1	21.9	25.2	86.1
Sec. 246: Coverage under medicare of optometrists' services with respect to aphakia	1.0	1.2	1.4	1.6	1.8	7.0
Sec. 247: Chiropractic services	4.5	23.4	27.3	31.3	26.1	122.6
Sec. 248: Treatment of plantar warts	1.5	2.3	2.7	3.1	3.6	13.2
Sec. 249: Limitation on reasonable cost and reasonable charge for outpatient services	—26.0	—61.7	—71.3	—81.5	—93.1	—333.6
Sec. 251: Confidentiality of PSRO data	0	0	0	0	0	0
Sec. 252: Procedures for determining reasonable cost and charge	0	—25.7	—63.1	—77.9	—95.7	—262.4
Sec. 253: Repeal of sec. 1867	0	0	0	0	0	0
Sec. 254: Development of uniform claims forms for use under health care programs	0	0	0	0	0	0
Sec. 255: Medicare liability where payment can be made under liability insurance policy	—95.0	—145.3	—209.8	—241.9	—278.5	—970.5
Sec. 256: Judicial district in which providers may obtain judicial review	0	0	0	0	0	0
Sec. 257: Resources of medicaid applicant	—5.0	—8.1	—11.7	—16.1	—17.7	—58.6
Sec. 258: Payment for laboratory services and certain medical devices under medicaid	—16.8	—38.0	—42.3	—33.4	—21.9	—152.4
Sec. 259: Authority for certain States to buy-in coverage under pt. B of medicare for certain medicaid recipients	.6	.6	.6	.8	.8	3.4
Sec. 260: Extension of period for funding of State medicaid fraud control units	0	14.8	4.3	0	0	19.1
Sec. 261: Medicaid payments to States	158.0	0	0	0	0	—158.0
Sec. 262: Notification to State officials	0	0	0	0	0	0
Sec. 263: Waiver of human experimentation provision for medicare and medicaid	0	0	0	0	0	0
Sec. 264: Disclosure of medicaid information	0	0	0	0	0	0
Sec. 265: Demonstration projects for training and employment of AFDC recipients as nomemakers and home health aides	1.0	—6.6	—32.0	—43.6	—48.2	—129.4
Sec. 266: Grants to regional pediatric pulmonary centers	2.5	5.0	5.0	5.0	5.0	22.5
Sec. 267: Administrator of HCFA	0	0	0	0	0	0
Sec. 268: PSRO participation by certain practitioners	0	0	0	0	0	0
Sec. 269: Nonphysician membership on national PSRO council	0	0	0	0	0	0
Grand total	—698.9	—881.6	—1,803.8	—2,490.0	—3,378.9	—9,253.2

The above table represents the Committee's best estimate of the net impact of the bill on Federal expenditures. During the course of considering the bill and preparing the report, the Committee received estimates of the cost of provisions prepared by the Congressional Budget Office. A formal estimate was received from the Congressional Budget Office on October 25, 1979. This CBO estimate is included in this report following this segment. The CBO estimate differs in some respects from the Committee estimates shown in the table. A discussion of the reasons for the Committee estimates and areas of difference with the CBO estimate is given below.

Section 202—Criteria for determining reasonable cost of hospital services.—The Committee estimate of savings for section 202 is considerably higher than that of CBO. The reason for the difference is because CBO assumes that the provisions of the section will apply only to adjusted hospital routine costs and not extend to hospital ancillary services or other types of facilities during the five-year period. In view of statements by the Administration that it expects to go to a "case mix" basis of reimbursement in FY 1981, which by definition would include ancillary hospital costs, the Committee believes the CBO estimate is unrealistic. In earlier work prepared for the Committee, CBO had estimated the savings which would accrue to Medicare and Medicaid if increases in reimbursement for hospital ancillary costs were limited to increases in the cost of a "market basket" of goods and services used in producing the ancillary services. The Committee estimate of costs under the bill are based in part on estimates of savings due to the ancillary cost limit equal to one-half of the savings estimated by CBO to reflect expectations of additional costs due to allowance to hospitals for appropriate increases in the intensity of services as well as payment of incentive allowances. No savings are included in the Committee estimate for fiscal year 1980 and, despite the Administration's anticipation of inclusion of ancillary services through the case mix approach in 1981, a total of only $200 million in savings is shown in that year under the Committee estimate for both routine and ancillary costs. The Committee believes it is reasonable to assume that ancillary costs will be encompassed under section 202 authority during fiscal year 1982 and subsequent years.

Section 211—Reimbursement of inappropriate inpatient hospital services.—The Committee has received extensive information and testimony regarding the magnitude of inappropriate use of high-cost hospital beds by Medicare and Medicaid patients who are in need of long-term skilled nursing facility and intermediate facility care. More recently, extensive testimony was received at hearings held by the Committee on September 18 and 19 of this year. The information is such as to clearly indicate that reductions in cost as a result of the Committee amendment can reasonably be anticipated to be of substantially greater magnitude than that included in the CBO estimate.

Section 213—PSRO review of hospital admissions, routine testing and preoperative stays.—For reasons similar to those outlined in the discussion of the Committee's estimate of savings under section 211, the CBO estimate of savings for this section has been increased. PSRO's have testified and provided information to the Committee concerning widespread inappropriate admission of patients on weekends for elective procedures and services where the hospital was not

equipped or staffed to provide the necessary care. Similarly, they have highlighted extensive routine overtesting of patients and excessive preoperative stays for elective procedures.

Sections 228, 245 and 247.—With respect to these sections, the Committee's estimate differs with that of CBO only for fiscal year 1980. The difference results from the Committee's decision to postpone effective dates of these sections—decisions made subsequent to preparation of the CBO estimate.

The estimate prepared by the Congressional Budget Office is printed below:

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

October 25, 1979.

1. Bill number: H.R. 934.

2. Bill title: Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979.

3. Bill status: As ordered reported by the Senate Committee on Finance on June 28, 1979.

4. Bill purpose: The bill contains sixty provisions, almost all of which amend Title XVIII (Medicare) and/or Title XIX (Medicaid) of the Social Security Act. The overall thrust of the bill is to generate savings to these programs, although there are a number of benefit expansion provisions which offset a portion of the savings. Furthermore, 31 provisions have little or no cost impact because they provide either for administrative and technical changes or for studies of various aspects of program reimbursement procedures. What follows is a brief description of the major provisions in the bill which have a cost or savings impact.

Section 202 of the bill would establish a new method of reimbursing hospitals for routine operating costs under the medicare and medicaid programs. Routine costs greater than 115 percent of the average for similar hospitals would not be reimbursed. The upper limit would be lowered relative to the average each year as a result of the method that would be used to calculate limits for groups of similar hospitals. Hospitals with costs below the average would receive bonus payments. The section also would establish a Health Facilities Cost Commission which would study the problem of rising costs and make recommendations as to further measures to contain them.

The bill contains several other provisions that would affect hospital reimbursement. Section 203 would provide for payments to hospitals that close, or convert to alternative uses, facilities that are underutilized. Section 204 would change the current law limitations on medicare and medicaid payments related to capital expenditures by health care facilities and home health agencies. Section 205 would increase the rate of return on net equity allowed for purposes of medicare reimbursement to properietary hospitals. The amount of increase allowed a particular hospital would be tied to its performance under the limits on routine costs established by Section 202. Section 210 would eliminate special differentials paid by medicare for some cost items of hospitals, nursing costs in particular. Section 211 would require that medicare and medicaid reimbursement be made for the level of care appropriate to a medicare or medicaid patient's needs regardless of the setting in which the care was rendered. This provision is designed to prevent payment at hospital rates for care rendered pa-

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tients who would be more appropriately treated in nursing homes or detoxification facilities. Section 212 would establish a program of grants and loans to encourage the conversion of underutilized hospital space to long-term care facilities. Section 213 would direct Professional Standards Review Organizations (PSRO's) to review the appropriateness of early hospital admissions, routine laboratory tests, and preoperative stays.

The bill contains several provisions relating to skilled nursing facilities, intermediate care facilities, and home health care. Section 221 would make it possible for small hospitals to use underutilized beds for skilled nursing care without having to establish formally a skilled nursing facility. Section 227 would modify the medicare reasonable cost criterion as it relates to reimbursement of nursing homes by state medicaid programs. Section 228 would expand the medicare home health benefit by removing the three-day prior hospitalization requirements under Part A and by removing the one hundred visit limitation under both Parts A and B. The provision would establish new administrative procedures to aid in moderating the rise in the cost of home health care.

The bill includes a number of provisions which would affect the scope and reimbursement of services rendered by a variety of health care practitioners. Section 231 would provide for faster processing of claims for physicians who agree to accept assignment. Under Section 234, physicians performing surgery in their offices would be compensated for their services through all-inclusive, prospectively established rates, provided that they accept assignment. Section 235 would change the criteria for determining reasonable charges for physicians' fees by limiting the difference between the highest local fee and the statewide median fee for a procedure to one-third of the statewide median. Section 243 would establish comprehensive outpatient rehabilitation centers as a new class of provider under medicare. Section 245 would provide that dentists be reimbursed for dentally-related procedures for which reimbursement is currently made only if they are performed by a physician. The section also would provide for coverage of dentally-related hospital stays where hospitalization is warranted by either the severity of the patient's condition or the dental condition. Section 249 would place limits on reasonable cost and reasonable charge for outpatient services by relating them to the costs of the same services performed in a physician's office.

Finally, the bill contains a variety of other provisions which would affect the medicare and medicaid programs. Section 255 would provide that the liability of the medicare program be secondary to that of an accident or automobile insurance program for care rendered an accident victim eligible for medicare. Section 257 would prohibit medicaid applicants from disposing of assets at less than fair market value in order to obtain program eligibility. Section 258 would provide for competitive bidding arrangements under medicaid for purchase of laboratory services and medical devices such as eyeglasses and hearing aides. Section 259 would allow states that have not done so already to make arrangements to buy medicare Part B coverage for their medicaid recipients who are also eligible for medicare. The section also would allow states to buy Part B coverage for their medically needy (non-cash assistance) recipients if they have not done so already. Section 261

would extend to all states a change in the method by which they are reimbursed by the federal government for their medicaid costs. Section 265 would provide for demonstration projects for the training and employment of AFDC recipients as homemakers and home health aides.

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
(a) Direct spending provisions:					
Medicare (function 550):					
Estimated budget authority:					
Sec. 259: Authority for State medicaid plans to buy medicare pt. B coverage	0.3	0.3	0.3	0.4	0.4
Estimated outlays:					
Sec. 202: Criteria for determining reasonable cost of hospital services:					
Routine cost limits	0	10.0	130.0	160.0	175.0
Payments to States for hospital cost control commissions	.3	3.3	4.4	5.6	6.9
Sec. 203: Closure and conversion of underutilized hospital facilities	0	−1.5	−7.3	−19.4	−36.0
Sec. 205: Rate of return on net equity for proprietary hospitals	3.2	50.5	59.1	68.5	78.8
Sec. 206: Coordinated audits	−3.0	−6.5	−7.1	−7.6	−8.2
Sec. 210: Apportionment of provider costs	−183.0	−209.7	−241.8	−278.8	−321.2
Sec. 211: Reimbursement for inappropriate hospital services	−11.0	−25.6	−29.7	− 34.5	−40.0
Sec. 212: Conversion to LTC facility	1.0	5.0	4.0	0	0
Sec. 213: PSRO review of routine testing and preoperative stays	−22.0	−51.2	−60.2	−71.6	−84.9
Sec. 228: Home health benefits	7.6	18.2	21.2	25.0	28.4
Sec. 234: Ambulatory surgery	−6.2	−11.3	−24.7	−57.9	−101.3
Sec. 235: Criteria for determining reasonable charge of physicians' services	0	−5.0	−10.0	−15.0	−20.0
Sec. 237: Payment for antigens	.1	.2	.2	.3	.3
Sec. 243: Outpatient rehabilitation services	1.5	11.0	12.8	14.7	16.9
Sec. 244: Ambulance services	.5	1.1	1.3	1.5	1.7
Sec. 245: Coverage of certain dentists' services	14.0	16.4	19.1	21.9	25.2
Sec. 246: Coverage of aphakia treatment	1.0	1.2	1.4	1.6	1.8
Sec. 247: Chiropractic services	15.0	23.4	27.3	31.3	36.1
Sec. 248: Treatment of plantar warts	1.5	2.3	2.7	3.1	3.6
Sec. 249: Limit on reasonable cost of outpatient services	−22.0	−52.7	−61.3	−70.5	−81.1
Sec. 252: Procedures for determining reasonable cost	0	−21.4	−52.6	−64.9	−79.7
Sec. 255: Medicare liability secondary to accident policy liability	−95.0	−145.3	−209.8	−241.9	−278.5
Sec. 259: Authority for State medicaid plans to buy medicare pt. B coverage	.3	.3	.3	.4	.4
Total, medicare outlays	−296.2	−387.3	−420.7	−528.2	−675.8
(b) Amounts subject to appropriation action:					
Medicaid (function 550):					
Required budget authority	−51.5	−110.0	−176.3	−204.9	−219.1
Estimated outlays:					
Sec. 202: Criteria for determining reasonable cost of hospital services:					
Routine cost limits	0	0	−10.0	−15.0	−20.0
Payments to States for hospital cost control commissions	.1	.6	.8	1.0	1.3
Sec. 203: Closure and conversion of underutilized hospital facilities	0	−.3	−1.6	−4.2	−7.7
Sec. 206: Coordinated audits	−14.0	−30.5	−33.0	−35.6	−38.5
Sec. 211: Reimbursement for inappropriate hospital services	−9.7	−22.2	−25.4	−29.0	−33.1
Sec. 213: PSRO review of routine testing and preoperative stays	−2.2	−4.9	−5.5	−6.0	−6.6
Sec. 228: Home health benefits	−1.0	−2.2	−2.5	−2.7	−3.0
Sec. 249: Limit on resonable cost of outpatient services	−4.0	−9.0	−10.0	−11.0	−12.0
Sec. 252: Procedures for determining reasonable cost and charge	0	−4.3	−10.5	−13.0	−16.0
Sec. 257: Resources of medicaid applicant	−5.0	−8.1	−11.7	−16.1	−17.7
Sec. 258: Payment for laboratory services and medical devices	−16.8	−38.0	−42.3	−33.4	−21.9
Sec. 259: Authority for State medicaid plans to buy pt. B medicare coverage	.1	.1	.1	.1	.1
Sec. 260: Extension of funding for State fraud control units	0	14.8	4.3	0	0
Sec. 261: Medicaid payments to States	−158.0	0	0	0	0
Sec. 265: Demonstration projects for training AFDC recipients	1.0	−6.0	−29.0	−40.0	−44.0
Total, medicaid outlays	−209.5	−110.0	−176.3	−204.9	−219.1

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
(b) Amounts subject to appropriation action—Continued					
Medicaid (function 550)—Continued					
AFDC (function 600):					
Required budget authority:					
Sec. 265: Demonstration projects for training AFDC recipients	0	−.6	−3.0	−3.6	−4.2
Estimated outlays:					
Sec. 265: Demonstration projects for training AFDC recipients	0	−.6	−3.0	−3.6	−4.2
Other provisions (function 550):					
Authorization level:					
Sec. 202: Health facilities cost commission (estimated)	.2	.2	.2	.3	.3
Sec. 212: Conversion to LTC facility	50.0	0	0	0	0
Sec. 259: Authority for State medicaid plans to buy pt. B medicare coverage (estimated)	.2	.2	.2	.3	.3
Sec. 266: Grants to regional pediatric pulmonary centers	5.0	5.0	5.0	5.0	5.0
Total	55.4	5.4	5.4	5.6	5.6
Estimated outlays:					
Sec. 202: Health facilities cost commission (estimated)	.2	.2	.2	.3	.3
Sec. 212: Conversion to LTC facility	5.0	25.0	20.0	0	0
Sec. 259: Authority for State medicaid plans to buy pt. B medicare coverage	.2	.2	.2	.3	.3
Sec. 266: Grants to regional pediatric pulmonary centers	2.5	5.0	5.0	5.0	5.0
Total	7.9	30.4	25.4	5.6	5.6
Summary of outlay impact:					
Direct spending	−296.2	−387.3	−420.7	−528.2	−675.8
Amounts subject to appropriation action	−201.6	−80.2	−153.9	−202.9	−217.7
Total	−497.8	−467.5	−574.6	−731.1	−893.5

Portions of the bill would reduce future federal liabilities through a change to an existing entitlement and therefore could permit subsequent appropriations action to reduce the budget authority for the medicaid program. The figures shown as "Required Budget Authority" represent that amount by which budget authority for the medicaid program could be reduced, as a result of this bill, below the level needed under current law.

6. Basis of estimate: This cost estimate assumes enactment by November 30, 1979. Effective dates of individual provisions are discussed below.

SECTION 202—CRITERIA FOR DETERMINING COST OF ROUTINE HOSPITAL SERVICES

The costs of the routine cost reimbursement reforms are determined using estimates provided by the Office of the Medicare Actuary, HEW, and by adjusting HEW simulations of individual hospitals' costs to reflect CBO's current policy projections for medicare and medicaid hospital expenditures for 1980–84 and to account for specific provisions of H.R. 934. The HEW simulations use 1974 and 1975 data from a sample of hospitals. These sample data are adjusted to represent all hospitals.

Per diem routine hospital costs are assumed to rise at approximately 12 percent per year during the 1980–1984 period. The upper limit on reimbursable costs (115 percent of each hospital group average in

1980) will increase each year by a dollar amount equal to about 12 percent of each hospital group's average.

This bill excludes from routine costs all capital costs, education and training costs, energy costs, malpractice insurance costs, and intern, resident, and nonadministrative physician costs. These excluded costs amount to about 30 percent of total routine costs in all hospitals.

The bill provides much less stringent limits for hospitals with lengths-of-stay below the average for their groups than for hospitals with lengths of stay at or above the average. The limit for a hospital with an average length-of-stay per patient shorter than the average of its group would equal the greater of: (1) the limits described above; or (2) the average reimbursement for routine operating costs per admission for hospitals ni its group times the rospital's number of admissions. The reimbursements could not exceed the actual routine operating costs of the hospital.

States which have cost containment programs covering medicare and medicaid would be exempted from the provisions of Section 202. Since only three state cost containment programs now cover medicare, it is assumed that the accrued savings would not be significantly affected by such exemptions.

The new reimbursement system would take the place of the routine cost limits already established under Section 223 of the Social Security Amendments of 1972. The current limits are similar to the proposed limits in many respects. The proposed system would differ from the current limits in that it would provide that bonuses be paid to hospitals that experience rates of increase in routine costs that are below the average for their group. As a result, although the proposed system would generate gross savings that would exceed those currently being achieved under the Section 223 regulations, these savings would be more than offset by the bonuses that would be paid. Therefore, the provision results in a net additional cost to the Hospital Insurance (HI) program. Small savings accrue to the medicaid program because the bonuses would be paid out of the HI trust fund.

In view of the fact that during the last several years both the Congress and the Administration have viewed rising hospital costs as an important national problem, it is conceivable that the Health Facilities Cost Commission established by Section 202 would move quickly to recommend implementation of a system of ancillary cost limits. Such limits would result in additional federal savings, but they cannot at this time be included in the savings for Section 202 because the section in its current wording does not mandate their establishment. Moreover, HEW currently has the authority under Section 223 of P.L. 92–603 to establish a system of ancillary cost limits but has not to date because of the technical problems involved. Therefore, since such a system could take a variety of different forms, it is not possible for CBO to predict or specify the future actions of either HEW or the Commission with respect to its development and implementation.

The costs of the Health Facilities Cost Commission would be those of holding the monthly Commission meetings, since the bill states that HEW would provide the staff and technical support. Salary and travel expenses of the commission members are estimated to be about $200,000 in fiscal year 1980.

Finally, Section 202 provides funds for the administrative costs of state hospital cost commissions. The commissions would be reimbursed by the federal government for a portion of their administrative costs equal to the proportion that medicare and medicaid hospital expenditures represent of all hospital expenditures covered by the state commissions. The estimated participation and costs of this provision are:

[By fiscal years, in millions of dollars]

	1980	1981	1982	1983	1984
Number of States	3	10	12	14	16
Medicare	$0.3	$3.3	$4.4	$5.6	$6.9
Medicaid	$0.1	$0.6	$0.8	$1.0	$1.3

Net savings for conversions are obtained by multiplying the net savings for all 15 converted beds per hospital times the number of hospitals undergoing conversions in each fiscal year. Outyear savings grow in conformance with CBO's latest projections of the rate of growth in total hospital expense per day, skilled nursing care expense per day, hospital construction costs, and the Consumer Price Index (CPI).

Partial closures are assumed to involve 15 beds per hospital for the same reasons cited in the case of conversion. It is assumed that the space made available by a partial closure would be put to some other use, such as administrative offices or educational facilities. Therefore, conversion costs per bed are assumed to be one-half those involved in conversion to a lesser level of care. As in the case of conversion above, it is assumed that these costs would be paid in the form of depreciation and interest payments over a 20-year period. Interest costs are higher in the first year due to construction loan financing. Severance pay and miscellaneous costs are assumed to be the same as in the case of conversion to a lesser level of care. Savings are assumed to be only one-quarter of total acute care operating costs per bed since the majority of the fixed costs of the space converted to non-care uses would remain. Net savings are calculated by multiplying the net savings per bed times the number of beds closed per hospital (15) times the number of hospitals undertaking partial closures in each year. Savings in the outyears grow in the same manner as those for conversion to a lesser level of care.

In the case of hospitals undergoing total closure, it is assumed that only hospitals with less than 200 beds would take this action. The average number of beds for these hospitals is 80. The annual growth rate in plant assets per bed for 1974 to 1977 was 11 percent. It is estimated from this growth rate and American Hospital Association (AHA) data for 1977 that the value of plant assets per bed will be about $69,000 and long-term debt per bed will be about $24,000 in fiscal year 1982. It is assumed that payment will be made for the long-term debt per bed less salvage value, which is assumed to be 10 percent of the value of plant assets per bed. Severance pay and miscellaneous expenses are estimated to be $5,400 per bed in fiscal year 1982. The closure payment for capital debt is assumed to continue to grow at 11 percent per year in subsequent years. Severance pay costs are assumed to grow at the same rate as CBO's projections of the CPI. Hospitals with less than 200 beds have operating expenses per day that are 24 percent below the national average. It is thus assumed that 76 percent of CBO's latest projection

of the national average annual cost per bed, $116,000, will be saved for each bed taken out of service. Savings are assumed to grow at the same rate as CBO's latest projections of total hospital expense per day.

SECTION 205—RATE OF RETURN ON EQUITY FOR FOR-PROFIT HOSPITALS

From American Hospital Association data it is estimated that the net equity per proprietary hospital in 1977 was $3.0 million. The historical annual growth rate of total assets per proprietary hospital is approximately 17 percent. This rate is used to project net equity for fiscal year 1980 and subsequent years. The simulation of the routine cost limits described in the explanation of the estimates for Section 202 provides the percentage of proprietary hospitals that would be entitled to a higher rate of return than currently allowed. These percentages are applied to the number of proprietary hospitals listed by the AHA in 1977 to yield 376 hospitals that would receive an additional 7 percent rate of return and 90 hospitals that would receive an additional 3.5 percent rate of return. The growth rate of 17 percent, the number of hospitals, the equity figure, and the incremental rate of return are multiplied to yield a total cost figure. Delays in implementation and lags due to the phasing of hospital accounting years are assumed to substantially reduce the cost of this provision in fiscal year 1980.

SECTION 203—PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

There are three types of activities that could occur as a result of this provision: conversion of acute care beds to a lesser level of care (conversion), closure of a portion of a hospital's acute care beds (partial closure), and complete closure of an entire acute care hospital. CBO assumes that conversion will be the predominant activity and that only a few total closures will occur. The provision limits to 50 the number of hospitals which may receive transitional allowances prior to January 1, 1983. Given the delays that would be incurred in establishing the Hospital Transitional Allowance Board and in processing applications, it is assumed that no allowances will be granted nor any savings realized until fiscal year 1981. It is further assumed that 49 hospitals will receive payments during fiscal years 1981 and 1982 and that 50 hospitals will receive payments in each fiscal year thereafter. The allocation of approved applications by type of activity is assumed to be as follows:

[Number of hospitals, by fiscal year]

	1980	1981	1982	1983	1984
Conversion	0	12	24	36	36
Partial closure	0	4	8	12	12
Total closure	0	0	1	2	2

For hospitals undergoing conversion, it is assumed that only hospitals with less than 400 beds will undertake such projects since hospitals with over 400 beds have occupancy rates close to 80 percent. Fifteen beds out of an average of 120 beds per hospital are assumed

to be converted since this would raise the acute care occupancy rate from an average of 65 percent to 74 percent. The conversion cost per bed in fiscal year 1981 is assumed to be $30,000, of which $25,000 is for renovation and $5,000 is for severance pay and other miscellaneous expenses. The renovation costs are assumed to be reimbursed over a 20 year period (the maximum permitted by the provision) in the form of reimbursement allowances for interest and depreciation. Interest costs in the first year are assumed to be higher than in subsequent years since it is likely that a construction loan would be the financing instrument during the actual renovation process. This loan would be rolled over into a 20 year mortgage after completion of the conversion. Severance pay and miscellaneous costs are assumed to be a once-only payment during the first year.

Savings from conversion are assumed to be generated by a transition from acute care to skilled nursing care. It is assumed that the Transitional Allowance Board will approve projects only for areas where shortages of nursing home beds exist. The converted beds are assumed, therefore, to be utilized to full capacity and thus to be filled at a 95 percent occupancy rate. All 15 converted beds per hospital are assumed to save one-half of the yearly operating cost of an acute care bed. Seven of the beds are assumed to be filled with skilled nursing care patients occupying acute care beds and awaiting placement into a nursing home. Based on CBO's projections of hospital expenses per day and medicare skilled nursing care expenses per day, a savings of $90 per day in fiscal year 1981 is assumed for these patients. These savings are assumed to be offset by a 40 percent refining of the vacated acute care beds at $283 per day. Another seven beds are assumed to be filled by previously uninstitutionalized skilled nursing care patients at a cost of $55 per day in fiscal year 1981. One bed is assumed to remain unoccupied and to generate fixed costs of 80 percent of the skilled nursing care daily rate.

SECTION 206—COORDINATED AUDITS

Sixteen states presently do not have coordinated audit programs. HEW estimates the savings for fiscal year 1980 to be $28.0 million for medicaid and $6.0 million for medicare. CBO assumes that delays in implementation will cut the savings in half in the first year. Outyear savings are inflated by CBO's current projections of the annual rate of increase in the Consumer Price Index.

SECTION 210—APPORTIONMENT OF PROVIDER COSTS

The savings of this provision are estimated to result from the elimination of the 8.5 percent differential for routine nursing costs currently allowed under medicare reimbursement. HEW estimates that this differential adds a one percent increment to medicare outlays for inpatient benefits. Data on hospitals' revenue and cost centers show that about 35 percent of revenues come from the general medicine and surgery cost centers and that 55 percent of all costs are non-phyiscian wages and fringe benefits. CBO assumes that 60 percent of these costs are attributable to routine nursing. First-year savings are de-

rived by applying these factors to projected medicare hospital expenditures in fiscal year 1980. Outyear savings are projected to grow at the same rate as total Hospital Insurance (HI) outlays. Fiscal year 1980 savings are reduced by 25 percent to account for delays in implementation.

SECTION 211—REIMBURSEMENT FOR INAPPROPRIATE INPATIENT HOSPITAL SERVICES

A statewide one-day census of all hospitals conducted recently by the PSROs in New York state revealed that 5 percent of all patients occupying acute care beds actually required long-term or other less intensive forms of care. Most of these patients receiving inappropriate acute care were medicare or medicaid beneficiaries, 60 and 25 percent respectively. A study by a New York PSRO provided data on the average length-of-stay of such patients. CBO assumes that 80 percent of the days in excess of national norms would be affected by the provision. It is calculated from this assumption and the New York PSRO data that the number of hospital days reimbursed at a lower rate would be 16 per medicare patient and 33 per medicaid patient.

The provision exempts geographic areas that do not have excess hospital beds. It is estimated on the basis of data provided by the Health Resources Administration that 10 percent of all beds, and thus 10 percent of the national average daily census, would be exempted. It is further assumed, on the basis of data contained in the New York PSRO study, that 90 percent of the affected patients would not be placed immediately into alternative care settings. Based on CBO's latest projections of national hospital expenditures, an average daily census of 731 thousand is estimated for fiscal year 1980 and is projected to grow to 766 thousand by the end of fiscal year 1984.

A savings of $80 is assumed in fiscal year 1980 for each day reimbursed at a lower rate. This grows to $130 per day in fiscal year 1984 as a consequence of the difference in the projected growth rates of hospital expenses per day and nursing home expenses per day. A first-year savings of $22.1 million in medicare and $19.5 million in medicaid is calculated for fiscal year 1980 and is assumed to be reduced in half to account for an April 1, 1980 effective date. Outyear savings grow consistent with the increase in the national average daily census and the projected savings per day.

SECTION 212—CONVERSION OF LONG-TERM CARE FACILITY

It is assumed that the $50 million authorized for fiscal year 1980 will be fully appropriated and that 10 percent will be spent in the first year, 50 percent in the second year, and the remainder in the third year. It is further assumed that loans out of the HI trust fund will be 20 percent of the grants made in each year.

SECTION 213—PSRO REVIEW OF HOSPITAL ADMISSIONS, ROUTINE TESTING, AND PREOPERATIVE STAYS

Savings from eliminating unnecessary routine tests are estimated on the assumption that six tests costing about $65 would be involved.

It is estimated that in fiscal year 1980 there will be 10.4 million short-stay admissions under the medicare program. Of these it is estimated on the basis of HI discharge data that 65 percent will be for non-surgical procedures. Based on a study by Blue Cross it is assumed that in 75 percent of these admissions the affected tests are done routinely. It is further assumed that 10 percent of these tests would be reduced by the increased priority placed by the provision on the review by PSROs of their necessity. The foregoing assumptions yield, through a multiplicative relationship, first year savings in HI outlays of $33 million in fiscal year 1980. These are assumed to be reduced in half in fiscal year 1980 due to delays in implementation. Outyear savings are projected to increase by both the rate of growth in medicare hospital admissions, 5 percent per year, and by CBO's latest projections in the rate of growth in the medical care services component of the Consumer Price Index. These tests are calculated to cost about $280 million in fiscal year 1980, of which 15 percent is assumed to be saved.

It is estimated for fiscal year 1980 that there will be about 6.8 million preoperative days of care for elective surgical procedures financed by HI. On the basis of recent findings by a CBO study of PRSOs, it is assumed that 2 percent of these days would be eliminaated. At an assumed $132 in routine costs per day, first year savings would be $17.9 million. The savings are partially offset by $5.1 million for administrative costs. Due to delays in implementation, first-year savings are assumed to be halved. Outyear savings are projected to increase by both the rate of growth in HI surgical admissions, 7 percent per year, and by CBO's latest projections of the rate of increase in hospital expense per day.

Medicaid savings are assumed to be 20 percent of total medicare savings, based on the relative shares of total hospital expenditures financed by these two programs. Outyear savings are projected to grow at the same rate as total medicaid outlays.

SECTION 228—HOME HEALTH BENEFIT PROVISIONS

Medicare data for calendar year 1977 show that about 15 thousand people reached the hundred visit limit under Part A or B. CBO assumes that one-third of these people would use about 40 extra visits each per year at a cost of $30 per visit in fiscal year 1980. It is further assumed that one million people covered by HI do not have SMI coverage. These people would be eligible to receive extra visits under the provision. On the basis of medicare data on home health utilization rates it is calculated that six thousand people would incur 30 extra visits each at a cost of $30 per visit.

The resulting cost figures are aged to 1980 to account for a 10 percent per year growth in the home health patient population since 1977. First year costs are reduced in half to account for an effective date of April 1, 1980. Outyear costs are projected to grow at the substantial rates of program growth experienced in the past several years with some tapering off in the growth rate expected by fiscal year 1984.

Medicaid savings are estimated to be generated by the transfer of about four thousand people back to medicare financing. Each person is issumed to incur 50 visits at a cost of $30, of which 27.5 percent

would be incremental federal costs. First-year savings are reduced in half to account for the provision's effective date. Outyear savings are projected to grow at the same rate as the medicaid program.

The section also provides for administrative changes in the home health reimbursement mechanism. It is assumed that these changes would generate modest savings in the outyears.

SECTION 243—CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

The parts of this section which provide for reimbursement for surgery done on an ambulatory basis will result in both savings and costs to the medicare program. Savings are generated by the lower cost of minor surgery done in an ambulatory rather than an inpatient setting. Costs are generated by the likely increase in the number of minor operations done because of the greater convenience to patients of an ambulatory setting.

Medicare hospital discharge data for 1977 show that 43 percent of HI expenditures for short-stay hospital services is spent for surgical procedures. A three-year study of the costs and quality of surgery performed in different settings which was done by the Orkand Corporation for HEW showed that the total costs of minor surgery done in an ambulatory setting is about 25 percent less than what it is in an inpatient setting. The study also showed that in the Phoenix area about six percent of all surgical procedures financed by medicare were performed in an ambulatory setting. CBO assumes that minor operations cost 60 percent of the average cost for all surgical procedures financed by medicare. It is further assumed that .5 percent of all medicare-financed operations will be done in an ambulatory setting in fiscal year 1980 and that this figure will increase to 6 percent in fiscal year 1984. These assumptions, combined with a 25 percent savings rate per operation and CBO's projections of the growth in HI outlays, produce savings to the medicare program of $7.2 million in fiscal year 1980. The savings rise to $152.4 million in fiscal year 1984. CBO expects these savings to be reduced slightly by HI's share in the costs produced by an assumed 40 percent refilling of the empty hospital beds created by the shift of minor operations out of hospitals. Each refilled bed is assumed to generate 1.5 days of ultilization costing $251 per day in fiscal year 1980. The resulting offset is $0.7 million in fiscal year 1980 which grows by an average of 20 percent in each succeeding year in conformance with increases projected by CBO in the average cost per hospital day and the number of operations financed by HI.

The costs of the additional demand for minor operations are estimated under the assumption that the number of medicare-financed operations that can be performed on an ambulatory basis will increase by one percent in fiscal year 1980. This percentage increase is assumed to grow to 10 percent in fiscal year 1984. All other assumptions and factors are the same as those used above to estimate the savings. The costs are calculated to be $1.3 million in fiscal year 1980 and are projected to rise to $45.7 million in fiscal year 1984.

The section also provides incentives for presurgical diagnostic tests to be done on an outpatient basis seven days prior to admission for a surgical procedure. This provision would generate savings through a

reduction in the number of preoperative days financed by medicare. Section 213 of the bill directs PSROs to give priority to review of the appropriateness of preoperative stays. Since a separate estimate is shown for the impact of Section 213 in reducing the umber of medicare-financed preoperative days, it is assumed that only minor incremental savings would be generated by the similar effect of this section. These are estimated as follows: It is assumed that half of a projected 6.4 million medicare financed operations in fiscal year 1980 could possibly be effected by this provision. It is further assumed that 0.5 percent of these operations will actually be affected in fiscal year 1980. Performing tests on an outpatient basis is assumed to save $132 in routine per diem costs per operation in fiscal year 1980. The resulting first-year savings are $2.1 million. Outyear savings grow to $22.3 million in fiscal year 1984 as a result of: (1) an assumed 7 percent per year growth in the number of medicare-financed operations; (2) growth in the percentage of affected operations from 0.5 percent in fiscal year 1980 to 2.5 percent in fiscal year 1984; and (3) increases in routine per diem costs averaging 12.5 percent per year through fiscal year 1984. Finally, the savings in each year are assumed to be reduced by 10 percent to account for HI's share in the costs generated by an assumed 40 percent refilling of the empty hospital beds created by the increased number of preoperative tests done on an outpatient basis.

SECTION 235—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

The cost estimates included here were developed by the Office of the Actuary/Medicare of HEW. The provision affects physicians' fees in two ways. First, it limits the difference between local prevailing fees and the statewide median fee for a procedure to one-third of the latter. The savings estimate is generated by a computer simulation of the effect of the limitation using data on 1976 medicare prevailing charges for the 50 most commonly performed physician services. The second effect of the provision is to raise the allowable prevailing charge from the 50th to the 75th percentile for new and established physicians practicing in designated physician-shortage areas. The estimate is derived from data on prevailing charges and the number of physicians practicing in physician-shortage areas.

SECTION 237—PAYMENT FOR CERTAIN ANTIGENS FOR MEDICARE

This provision is estimated to have an almost negligible cost impact. The figures shown are included only in order to indicate the small amounts that are likely to be involved.

SECTION 243—COMPREHENSIVE OUTPATIENT REHABILITATION CENTERS

The estimates included here were developed by the Office of the Actuary/Medicare of HEW. First year costs are assumed to be small because of the July 1, 1980 effective date. Outyear costs are projected to grow at the same rate as total Supplementary Medical Insurance (SMI) expenditures.

SECTION 244—AMBULANCE SERVICES

An estimate of $1.0 million for fiscal year 1980 was provided by the Office of the Actuary/Medicare of HEW. This was assumed to be halved due to the effective date of the provision. Outyear costs were derived by inflating the first year cost by the rate of growth in the medicare program.

SECTION 245—COVERAGE UNDER MEDICARE OF CERTAIN DENTISTS' SERVICES

The first-year costs shown above were supplied by the Office of the Actuary/Medicare of HEW. For the first subsection, data on the number of affected procedures that are currently done by oral surgeons and paid for by medicare were used to yield a $5.0 million first-year cost. For the second subsection, data were obtained on the number of medicare recipients that see a dentist annually and the percentage of procedures likely to be serious. A series of assumptions were then made about the number of cases that would already be covered, the number that would be serious enough to warrant hospitalization, and the number of people that would actually enter the hospital for such procedures. A full first-year cost is assumed because of an effective date of October 1, 1979. CBO has projected the first year costs to grow in the outyears at the same rate as overall SMI expenditures.

SECTION 246—COVERAGE UNDER MEDICARE OF OPTOMETRISTS' SERVICES WITH RESPECT TO APHAKIA

An estimate of $1.0 million for the first year costs of this provision was provided by the Office of the Actuary/Medicare of HEW. The estimate is based on program data on the amount of chiropractic services presently paid for by medicare and the number of additional services likely to be eligible for coverage if the X-ray requirement is liberalized. First year costs were assumed by CBO to be reduced by one-quarter to account for delays in implementation. Outyear costs are projected to grow at the same rate as overall SMI expenditures.

SECTION 247—CHIROPRACTIC SERVICES

An estimate of $20.0 million for the first year costs of this provision was provided by the Office of the Actuary/Medicare of HEW. The estimate is based on program data on the amount of chiropractic services presently paid for by medicare and the number of additional services likely to be eligible for coverage if medical findings other than an X-ray are permitted for establishing their necessity. First-year costs were assumed by CBO to be reduced by one-quarter to account for delays in implementation. Outyear costs are projected to grow at the same rate as overall SMI expenditures.

It is estimated that the medicaid program outlays for "other care" in fiscal year 1980 will be $262 million. Of this amount, 50 percent is assumed to be payments for medical devices. The federal share of this amount is 56 percent. A savings rate of 20 percent is assumed. First-year savings are expected to be halved by delays in implementation. Outyear savings are expected to grow at the same rate as total medicaid expenditures.

SECTION 259—AUTHORITY FOR CERTAIN STATES TO BUY-IN COVERAGE UNDER PART B OF MEDICARE FOR CERTAIN MEDICAID RECIPIENTS

This section would amend Section 1843 of the Social Security Act. Under Section 1843, until January 1, 1970, each state had the option of formalizing permanent agreements with HEW to purchase Medicare Supplementary Medical Insurance (Part B) on behalf of medicaid beneficiaries also eligible for medicare. The state could elect to cover all medicare-eligible medicaid recipients (MEMRs) or just those receiving cash payments. Today, all but four states (Alaska, Louisiana, Oregon, and Wyoming) and all jurisdictions but Puerto Rico have "buy-in" agreements with HEW. Twenty-one states, however, cover cash recipients only.

Section 259 would allow those states which do not now buy-in to medicare Part B to make buy-in agreements with HEW. It would also allow those states which cover cash recipients only to make buy-in arrangements for all MEMRs. The bill would limit to one year the period for making and altering buy-in agreements.

For this estimate, based on computations of state expenditures with and without buy-in agreements, it is assumed that only Alaska will commence buying-in to medicare Part B. Three considerations lead to this assumption. First, Alaska's high general medical price level should make very attractive any insurance with a premium determined nationally—like medicare Part B. Second, only about 45 percent of MEMRs in Alaska now enroll themselves in Part B. Generally, buying-in to Part B for persons who self-enroll would shift some premium expenses onto the state, thus increasing the state's medicaid costs. On the other hand, buying-in to Part B for unenrolled persons should lower state medicaid costs by transferring a large proportion of expenditures for medical services from the state to the federal government. It follows that the lower the proportion of Part B self-enrolled individuals in the population of MEMRs, the more likely it would be financially advantageous for the state to arrange a buy-in agreement. Third, Alaska's higher-than-average proportion of disabled among its MEMRs should also help make buying-in to Part B an attractive option. Medicare Part B premiums for the aged and disabled are identical, whereas medicaid expenditures per disabled recipient far exceed those per aged recipient. In the remaining states without buy-in agreements today, none of these factors appear to apply strongly enough to warrant initiation of such an agreement.

Federal costs reflecting a buy-in agreement for Alaska were computed as follows: 1) costs of federal medicaid matching for state Part B premium expenditures are the product of MEMRs times annual premiums times the 50 percent federal medicaid matching rate for Alaska; 2) Part B trust fund revenues from premiums are the product of MEMRs not self-enrolled times annual premiums (premium payments into the Part B trust fund on behalf of individuals currently self-enrolled do not change); 3) disbursements from the Part B trust fund for medical services are the sum of twice the adequate actuarial rate for the aged (twice $160.80) times aged MEMRs plus twice the adequate actuarial rate for the disabled (twice $300.00) times disabled

MEMRs; 4) contributions from general revenues to the Part B trust fund are the difference between estimates 3 and 2. For future years amounts are inflated consistent with current CBO inflation assumptions.

SECTION 248—TREATMENT OF PLANTAR WARTS

An estimate of $2.0 million for the first year costs was supplied by the Office of the Actuary/Medicare of HEW. CBO assumes that delays in implementation will reduce the cost by one-quarter in fiscal year 1980 and that outyear costs will grow at the same rate as overall SMI expenditures.

SECTION 249—LIMITATION ON REASONABLE COST AND CHARGE FOR OUTPATIENT SERVICES

The estimate is based on the assumption that all charges for outpatient visits that exceed by 80 percent charges for similar procedures performed in a physician's office would be reduced to the average charge per physician visit. About five percent of SMI outpatient charges are estimated to be reduced by one-half. The first-year savings to SMI are about 2.5 percent of total SMI outpatient expenditures. Federal medicaid savings are estimated to bear the same relationship to SMI savings as total federal medicaid outpatient expenditures do to SMI outpatient expenditures. First year costs are estimated to be reduced by one-half due to delays in implementation. Outyear savings are expected to increase at the same rate as total SMI and medicaid expenditures.

SECTION 252—PROCEDURES FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

This section provides that payments to contractors, subcontractors, employees, or consultants that are based upon percentage arrangements not be recognized for purposes of reimbursement by medicare. Due to a lack of data on the amount of medicare outlays that may be involved in all forms of percentage reimbursement arrangements, the estimate for this provision is limited to its impact on hospital-based physicians (HBPs). In their case, such arrangements would be permitted if the amount of reimbursement does not exceed the amount which would have been paid under an approved relative value schedule which takes into account the physician's time and effort.

Savings were estimated by assuming that payments would be reduced by the difference between what HBPs are paid on a percentage basis and what they would be paid as salaried employees. It is estimated on the basis of data available from the American Medical Association, Health Care Financing Administration (HCFA), and a recent study of HBPs done by the Arthur Anderson Company for HCFA, that approximately 1,000 radiologists and 1,600 pathologists would be affected by this provision. The Anderson study also provided data for 1975 on the difference in income between percentage-basis and salaried physicians in hospitals. This difference was adjusted for the overhead expenses assumed to be generated by the salaried physicians

and inflated to account for the growth in total hospital expenditures and physicians' incomes from 1975 to 1980. It was further assumed that only half of the apparent savings would be realized because of various adjustments likely to occur in the arrangements between the affected physicians and their hospitals. Since the relative value schedules on which an alternative reimbursement methodology would be based are currently in an early stage of development, it is assumed that implementation would occur at its earliest in the middle of fiscal year 1981. Half-year savings are thus assumed for that fiscal year and full-year savings thereafter.

SECTION 255—MEDICARE LIABILITY WHERE PAYMENT CAN BE MADE UNDER A LIABILITY INSURANCE POLICY

Medicare hospital discharge data show that 10 percent of all HI discharges are for diagnoses involving accidents of all types. Similar data from the National Ambulatory Medical Care Survey show that about 5 percent of all physican office visits by persons aged 65 or older are for accident-related conditions. It is assumed, therefore, that 10 percent of HI outlays and 5 percent of SMI outlays are for injuries resulting from accidents. Data from the Health Interview Survey show that about 50 percent of all accidents occurring in the 65 and older population at home, about 10 percent are related to automobile accidents, and 30 percent are due all other causes. Accidents occuring at home are unlikely to involve situations where liability insurance claims can be made. Similarly, accidents occurring in the workplace are likely to be covered by workers' compensation. It is assumed, therefore, that recoveries from liability insurance policies would be possible for all accidents except those occurring in the home or at work. The proportion of total medicare outlays spent for medical services related to each type of accident is assumed to be the same as the proportion each represents of all accidents.

For automobile accidents it is assumed for both HI and SMI that 95 percent of the accidents involving medicare beneficiaries occur where insurance coverage is present and that 80 percent of these have the potential for recovery of medical insurance payments. For all other accidents it is similarly assumed that 60 percent occur in circumstances in which liability insurance is present and that 80 percent of these have the potential for recoveries. For both types of accidents it is further assumed that the actual volume of recoveries will be 15 percent of the potential level in fiscal year 1980, 20 percent in fiscal year 1981, and 25 percent in fiscal year 1984 and thereafter.

SECTION 257—RESOURCES OF MEDICAID APPLICANT

An estimate of $5.0 million in savings in fiscal year 1980 was provided by HEW. This figure is based on the assumption that .4 percent of aged medicaid recipients would be affected by the provision in the first year, rising to 1 percent over the next three years. Full first year savings are anticipated because of an October 1, 1979 effective date. Outyear savings are projected by CBO to increase at rates consistent with the increase in the number of people affected by the provision and in the medical care services component of the CPI.

SECTION 258—PAYMENT FOR LABORATORY SERVICES AND CERTAIN MEDICAL DEVICES UNDER MEDICAID

CBO estimates that medicaid expenditures for laboratory and radiological services in fiscal year 1980 will be $230 million. The percentage laboratory services represents of the total is assumed to be 75 percent. The federal share of this amount is 56 percent. On the basis of the experience of studies done in New York, New Jersey, and California, it is estimated that a savings rate of 20 percent could be achieved under competitive bidding arrangements. First-year savings are assumed to be halved due to delays in implementation. The competitive bidding provision is only effective for three years, so full-year savings are assumed for fiscal years 1981 and 1982, and half-year savings in fiscal year 1983.

The state of Michigan which currently covers only cash recipients has indicated that, under Section 259, it would extend Part B coverage to all MEMRs. Financial considerations suggest that no other state will do so. Because nearly all of the people that Michigan proposes to cover currently self-enroll in Part B, Michigan's expected action will not significantly alter federal revenues, budget authoriy, or oulays.

SECTION 260—EXTENSION OF PERIOD OF FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS

The estimates shown were provided by HEW. They are based on the number of additional states expected to establish fraud control units and on the number of states with established units eligible for extra quarters of funding. Under the authority of Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142), the start-up costs of these units are eligible for 90 percent federal matching.

SECTION 261—MEDICAID PAYMENTS TO STATES

The estimate shown was provided by HEW. In fiscal year 1980, the Department will initiate a changeover from the current advance letter of credit system used by HEW to fund grantees to one where the federal outlay occurs only at the time a cashed check issued by the state to a provider is presented for payment at the state's bank. Implementation of this system would produce a one-time change in the federally outlay pattern. This cash management change would have no impact on budget authority. In fiscal year 1980, the Department is anticipating $243 million in savings from implementation of this system in the ten states that account for 60 percent of medicaid outlays. The provision mandates that HEW extend the system to all fifty states during fiscal year 1980, which would result in an additional $158 million in savings.

SECTION 262—GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

The authorization stated in the provision is assumed to be fully appropriated in each of the forthcoming fiscal years. Fifty percent

of each year's appropriation is expected to be spent in the current fiscal year and with the remainder being spent during the next fiscal year.

SECTION 265—DEMONSTRATION PROJECTS FOR TRAINING AFDC RECIPIENTS AS HOMEMAKERS AND HOME HEALTH AIDES

This provision would allow twelve states to have demonstration programs for training AFDC recipients to provide supportive services to people who might otherwise be expected to require institutional care in the absence of such services. The individuals to whom the services would be available include aged, disabled, and mentally retarded persons whose income does not exceed 200 percent of their state's standard of need. The provision would have both costs and savings. Costs would be incurred for the training of these AFDC recipients and later for federal payments to cover the wages and expenses of both the AFDC recipients and others employed in providing supportive services. Savings would result from not institutionalizing the individuals receiving the supportive services and from reduced benefit payments to those AFDC recipients employed in providing such services. Some savings would occur in the food stamps and medicaid programs as well as in the AFDC program.

ADDITIONAL PROVISIONS WITH LITTLE OR NO BUDGETARY IMPACT

The cost estimate shows only those provisions that have a cost or savings impact of $100,000 or more on the federal budget. There are twenty-nine other provisions which are estimated to have very little or no cost impact. Three of them mandate studies which are assumed to be financed out of HEW's general budget. Most of the provisions, however, involve a variety of changes in administrative or reimbursement procedures. Six of these 29 provisions are discussed below.

SECTION 204—FEDERAL PARTICIPATION IN CAPITAL EXPENDITURES

This provision strengthens the certificate-of-need process by requiring that planning agencies approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement of both capital and direct operating costs resulting from such expenditures. It is estimated that the provision will help the planning process achieve further savings, but the exact impact is difficult to separate out from the general impact of the planning program and other developments in the area of capital spending trends. Therefore, an estimate of the budgetary impact of this provision is not available at this time.

SECTION 221—HOSPITAL PROVIDERS OF LONG-TERM-CARE SERVICES

On the basis of discussions with the Office of the Actuary/Medicare of HEW, it is estimated that this provision will have a negligible impact on program costs. It is assumed that the cost savings generated on the inpatient side of an institution affected by the provision will be offset by the costs of the nursing care provided. This is based on the

assumption that hospitals are unlikely to take advantage of the provision unless they are able to maintain their current level of revenues or increase them.

SECTION 227—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

This section substitutes new language for the existing language of Section 1902(a)(13)(E) of the Social Security Act, more popularly known as Section 249 of Public Law 92–603, the Social Security Amendments of 1972. The current wording of Section 1902(a)(13)(E) requires that payment for SNF and ICF services be on a "reasonable cost related basis, as determined in accordance with methods which shall be developed by the state on the basis of cost-finding methods approved and verified by the Secretary". The proposed substitute language requires payment at rates "which are reasonable and adequate to meet the costs which are required to be incurred by a facility which is efficiently and economically operated in order to furnish such services" and "which assure the reasonable availability of long-term services to recipients of medical assistance under the plan to the same extent as such long-term care services are available to the general population." The report language expands upon this language by indicating that the revised section is intended to give states greater flexibility in setting rates without reference to medicare principles of reimbursement.

CBO has tried to assess the possible impact of the proposed new wording of Section 1902(a)(13)(E) through discussions with officials in eleven states who are involved in setting rates of payment for long-term care. These states (New York, California, Pennsylvania, Illinois, Michigan, Massachusetts, Texas, Ohio, New Jersey, Wisconsin, and Georgia) account for well over two-thirds of the medicaid program's outlays for nursing home care. The reactions to the section were varied: Some states may be able to achieve modest savings because the new wording would enable them to more successfully defend rate-setting procedures and rate levels in court actions. Other states indicate that there would be very little impact, if any, on their rates or rate-setting methodology. Still other states, however, have indicated that the new wording might result in their having to raise rates above what they might have been as a result of strict interpretation by courts of some of the new wording. It appears that the elimination of the Secretary's authority to approve rate-setting methodologies might give some states the flexibility to restrain the rate of increase in allowable nursing home reimbursements. Some of the state officials, however, felt that the stipulation concerning "reasonable availability" of services would have the opposite effect of increasing costs. Therefore, since the proposed substitute wording contains two clauses whose effects seem to cancel each other, CBO estimates that the provision will generate no net savings or costs in medicaid nursing home expenditures.

SECTION 231—AGREEMENTS WITH PHYSICIANS TO ACCEPT ASSIGNMENTS

This provision provides incentives for physicians to accept assignment by providing for expedited reimbursement procedures for bills

submitted on an assignment basis. There is a possibility that some physicians' overall charges might be lowered as a consequence of the provision, but these savings would accrue to patients, not medicare. Savings could occur to the program only if a substantial number of beneficiaries shifted over to physicians who both accept assignment and have lower usual or customary charges than other physicians. Since there is little basis for believing that this would happen, no savings are anticipated.

SECTION 232—USE OF APPROVED RELATIVE VALUE SCHEDULE

CBO believes that the use of relative value schedules has the potential for generating significant savings to the Supplementary Medical program. However, since research on such schedules is now only in its early stages, it is not known which physicians and types of procedures will be affected and to what degree. Therefore, it is not currently possible to estimate when savings would start to occur or what their magnitude would be.

SECTION 241—DEDUCTIBLE NOT APPLICABLE TO EXPENSES FOR CERTAIN INDEPENDENT LABORATORY TESTS

On the basis of discussions with the Office of the Actuary/Medicare of HEW, it is assumed that this provision will have a negligible cost impact. The provision corrects a drafting error made in the 1972 Amendments and waives the deductible requirement for certain laboratory services. It is likely, however, that most beneficiaries would have met the deductible already. Laboratories now probably forego collecting the copayment because of the administrative cost involved. If the copayment is waived, however, laboratories would have to accept assigned billing. The resulting change in financial incentives to laboratories therefore would be small.

7. Estimate comparison: Although several HEW estimates are quoted herein, there is currently no Administration estimate for the entire bill. Therefore, no estimate comparison is shown.

8. Previous CBO estimate: None.

9. Estimate prepared by: Eric Wedum, Malcolm Curtis, and Larry Wilson.

10. Estimate approved by:

James L. Blum,
Assistant Director for Budget Analysis.

IV. Vote of the Committee in Reporting the Bill

In compliance with paragraph 7(c) of Rule XXVI of the Standing Ruples of the Senate, the following statement is made relative to the vote by the committee to report the bill.

The bill was ordered repored by a voice vote.

V. Regulatory Impact of the Bill

In compliance with paragraph 6(b) of Rule XXVII of the Standing rules of the Senate the following evaluation is made of the regulatory impact which would be incurred in carrying out the bill.

In implementing the various provisions of the bill there will be some increase in Federal regulatory activity. It is not anticipated, however, that the legislation would impose an unusual or burdensome regulatory effect. Several provisions will, in fact, decrease regulatory activity and associated paperwork.

Section 202 of the bill would generate the most significant new regulatory activity since a new method of reimbursement under medicare and medicaid is required. Revised regulations will be necessary to implement a procedure for determining hospital "target" rates, as well as implement a procedure for determining exceptions to those rates. In addition, the Secretary would be required to implement procedures to evaluate State ratemaking programs for the purpose of determining exemptions from the Federal program.

The authorization for payments under the legislation to promote closing and conversion of underutilized facilities establishes a new procedure that would also require implementing regulations.

A provision that directs PSRO's to review certain questionable utilization practices would increase PSRO's review activities.

Provisions that will decrease regulations and paperwork include the simplified reimbursement procedure for long-term-care services provided by small rural hospitals; simplified claims procedure for "participating" physicians; coordinated audits under titles V, XVIII, and XIX; uniform claims forms under titles XVIII and XIX; prohibition against routine disclosure of aggregate payments to physicians; waiver of deductible under medicare for laboratory and rural health clinic services; authority for States to contract for clinical laboratory services and certain medical devices under medicaid; and clarification of present law regarding approval requirements for the changes of ownership of existing facilities which create no new beds or services.

VI. Changes in Existing Law

In compliance with paragraph 7 of Rule XXVII of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman) :

Social Security Act

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

Entitlement to Hospital Insurance Benefits

Sec. 226.

(a) Every individual who—

(1) has attained age 65, and

(2) is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (1), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Every individual who—

(1) has not attained age 65, and

(2) (A) is entitled to, and has for 24 consecutive calendar months been entitled to, (i) disability insurance benefits under section 223 or (ii) child's insurance benefits under section 202(d) by reason of a disability (as defined in section 223(d)) or (iii) widow's insurance benefits under section 202(e) or widower's insurance benefits under section 202(f) by reason of a disability (as defined in section 223(d)), or (B) is, and has been for not less than 24 consecutive months a disabled qualified railroad retirement beneficiary, within the meaning of section 7(d) of the Railroad Retirement Act of 1974,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (I) July 1973 or (II) for twenty-fifth consecutive month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and ending with the month following the month in which notice of termination of such entitlement to benefits or status as a qualified railroad retirement beneficiary described in paragraph (2) is mailed to him, or if earlier, with the month before the month in which he attains age 65.

(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and [post-hospital] home health services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or [post-hospital] home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

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TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

Purposes for Which Funds Are Available

Sec. 502. Appropriations pursuant to section 501 shall be available for the following purposes in the following proportions:

(1) In the case of the fiscal year ending June 30, 1969, and each of the next 5 fiscal years, (A) 50 percent of the appropriation for such year shall be for allotments pursuant to sections 503 and 504; (B) 40 percent thereof shall be for grants pursuant to sections 508, 509, and 510; and (C) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

(2) In the case of the fiscal year ending June 30, 1975, and each fiscal year thereafter, (A) 90 percent of the appropriation for such years shall be for allotments pursuant to sections 503 and 504; and (B) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511(*a*) and 512.

Not to exceed 5 percent of the appropriation for any fiscal year under this section shall be transferred, at the request of the Secretary, from one of the purposes specified in paragraph (1) or (2) to another purpose or purposes so specified. For each fiscal year, the Secretary

shall determine the portion of the appropriation, within the percentage determined above to be available for sections 503 and 504, which shall be available for allotment pursuant to section 503 and the portion thereof which shall be available for allotment pursuant to section 504. Notwithstanding the preceding provisions of this section, of the amount appropriated for any fiscal year pursuant to section 501, not less than 6 percent of the amount appropriated shall be available for family planning services from allotments under section 503 and for family planning services under projects under sections 508 and 512.

* * * * * * *

Approval of State Plans

Sec. 505. (a) Is order to be entitled to payments from allotments under section 502, a State must have a State plan for maternal and child health services and services for crippled children which—

* * * * * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall not be a prerequisite to eligibility for or the receipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864 (a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title[.] *; and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the portion of costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.

(b) The Secretary shall approve any plan which meets the requirements of subsection (a).

Payments

Sec. 506. (a) * * *

(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)]; *subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)*; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirement imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph in any State if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

(g) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(*h*) *For additional exclusions from reasonable cost and reasonable charge see section 1134.*

* * * * * * *

Training of Personnel

Sec. 511. (*a*) From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to public or nonprofit private

institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps. In making such grants the Secretary shall give special attention to programs providing training at the undergraduate level.

(b)(1) From the sums available under paragraph (2) the Secretary is authorized to make grants to public or nonprofit private regional pediatric pulmonary centers, which are part of (or affiliated with) an institution of higher learning, to assist them in carrying out a program for the training and instruction (through demonstrations and otherwise) of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases in children and young adults, and in providing (through such program) needed health care services to children and young adults suffering from such diseases.

(2) For the purpose of making grants under this subsection, there are authorized to be appropriated, for the fiscal year ending September 30, 1980, and each of the next four succeeding fiscal years, such sums (not in excess of $5,000,000 for any fiscal year) as may be necessary. Sums authorized to be appropriated for any fiscal year under this subsection for making grants for the purposes referred to in paragraph (1) shall be in addition to any sums authorized to be appropriated for such fiscal year for similar purposes under other provisions of this title.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

PART A—GENERAL PROVISIONS

* * * * * * *

Disclosure of Information in Possession of Department

Sec. 1106. (a) * * *

(f) The Secretary shall not make available, nor shall the State title XIX agency be required to make available to the public, information relating to the amounts that have been paid to individual doctors of medicine or osteopathy by or on behalf of beneficiaries of the health programs established by title XVIII or XIX, as the case may be, except as may be necessary to carry out the purposes of those titles or as may be specifically required by the provisions of other Federal law.

* * * * * * *

Limitation on Federal Participation for Capital Expenditures

Sec. 1122. [(a) The purpose of this section is to assure that Federal funds appropriated under title V, XVIII, and XIX are not used to support unnecessary capital expenditures made by or on behalf of health care facilities or health maintenance organizations which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.] *(a) The purpose of this section is to assure that Federal funds appropriated under titles V, XVIII, and XIX are not used to support unnecessary*

capital expenditures made by or on behalf of health care facilities (including those of health maintenance organizations) and home health agencies which are reimbursed under any of such titles and that, to the extent possible, reimbursement under such titles shall support planning activities with respect to health services and facilities in the various States.

(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency [(which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests)] (*which shall be the agency designated under section 1521 of the Public Health Service Act*) will—

[(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility or health maintenance organization in such State within the field of its responsibilities.

(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations in such State within the fields of their respective responsibilities, and]

(*1*) *make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility (including those of a health maintenance organization) or home health agency in such State within the field of its responsibilities,*

(*2*) *receive from the Health Systems Agencies designated under title XV of the Public Health Service Act, and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such agencies with respect to capital expenditures proposed by or on behalf of health care facilities (including those of health maintenance organizations) or home health agencies in such State within the fields of their respective responsibilities, and*

(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

[(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

[(d) (1) Except as provided in paragraph (2), if the Secretary determines that—

[(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

[(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligation for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

[(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

[(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

[(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

[then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles, V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital ex-

penditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

[(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVIII, or XIX, he shall not exclude such expenses pursuant to paragraph (1).]

(c) The reasonable expenses incurred in carrying out the activities referred to in subsection (b) by the designated planning agencies (disregarding any expenses for which the agency is authorized to be reimbursed from other sources) shall be payable from—

(1) funds in the Federal Hospital Insurance Trust Fund,

(2) funds in the Federal Supplementary Medical Insurance Trust Fund, and

(3) funds appropriated to carry out the health care provisions of the several titles of this Act,

in such amounts as the Secretary finds result in a proper allocation. The Secretary shall transfer money between the funds as may be appropriate to settle accounts between them. The Secretary shall pay the designated planning agencies without requiring contribution of funds by any State or political subdivision thereof.

(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

(A) the designated planning agency had not approved the proposed expenditure; and

(B) the designated planning agency had granted to the person proposing the capital expenditure an opportunity for a fair hearing with respect to the findings;

then, in determining Federal payments under titles V, XVIII, and XIX for services furnished in the health care facility for which the capital expenditure is made, the Secretary shall not include any amount attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), other expenses related to the capital expenditure, or for estimated direct operating costs, to the extent that they can be directly associated with the capital expenditures, unless the designated planning agency for the State determines, in accordance with an agreement entered into under subsection (b) or under a certificate of need program which is applicable to such expenditure and which meets the requirements of title XV of the Public Health Service Act, that such capital expenditures are needed and

meet criteria adopted by such agency. In the case of a proposed capital expenditure in a standard metropolitan statistical area which encompasses more than one jurisdiction, that expenditure shall require approval of the designated planning agency of each jurisdiction, which shall jointly review the proposal. Where the designated planning agencies do not unanimously agree, the proposed expenditures shall be deemed disapproved. Where the designated planning agencies do not act to approve or disapprove the proposed expenditure within one hundred and eighty days after the submission of the request for approval, the proposed expenditure shall be deemed approved. Any deemed approval or disapproval shall be subject to review and reversal by the Secretary following a request, submitted to him within sixty days of the deemed approval or disapproval, for a review and reconsideration based upon the record. With respect to any organization which is reimbursed on a per capita, fixed fee, or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount reasonably equivalent to the amount which would otherwise be excluded under this subsection if payment were made on other than a per capita, fixed fee, or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established under subsection (i), determines that an exclusion of expenses related to any capital expenditure would discourage the operation or expansion of any health care facility or health maintenance organization which has demonstrated to his satisfaction proof of its capability to provide comprehensive health care services (including institutional services) effectively and economically, or would be inconsistent with effective organization and delivery of health services, or the effective administration of title V, XVIII, or XIX, or would discriminate against the facilities of a health maintenance organization, he shall not exclude the expenses pursuant to paragraph (1), provided such expenditure is determined to be reasonable.

(e) Where a person obtains under lease or comparable arrangement any facility or part thereof, or equipment for a facility, which would have been subject to an exclusion under subsection (d) if the person had acquired it by purchase, the Secretary shall (1) in computing such person's rental expense in determining the Federal payments to be made under titles V, XVIII, and XIX with respect to services furnished in such facility, deduct the amount which in his judgment is a reasonable equivalent of the amount that would have been excluded if the person had acquired such facility or such equipment by purchase, and (2) in computing such person's return on equity capital deduct any amount deposited under the terms of the lease or comparable arrangement.

(f) Any person dissatisfied with a determination by the Secretary under this section may within six months following notification of such determination request the Secretary to reconsider such determination. A determination by the Secretary under this section shall not be subject to administrative or judicial review.

[(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and mainte-

nance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.]

(g) (1) For purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $150,000, (2) changes the bed capacity of the facility, or (3) substantially changes the services of the facility, including conversion of existing beds to higher cost usage. The cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion or replacement of the plant and equipment shall be included in determining whether the expenditure exceeds $150,000. For purposes of this section, "capital expenditure" does not include an expenditure for the purpose of acquiring (either by purchase or under lease or comparable arrangement) an existing health care facility, the utilized services and bed capacity of which are not increased as a result of the acquisition.

(2) For purposes of this section, the establishment of a home health agency shall be considered to be a capital expenditure by such agency, without regard to the amount of the expenditure involved in establishing such agency.

(h) The provisions of this section shall not apply to Christian Science sanatoriums operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

(i) (1) The Secretary shall establish a national advisory council, or designate an appropriate existing national advisory council, to advise and assist him in the preparation of general regulations to carry out the purposes of this section and on policy matters arising in the administration of this section, including the coordination of activities under this section with those under other parts of this Act or under other Federal or federally assisted health programs.

(2) The Secretary shall make appropriate provision for consultation between and coordination of the work of the advisory council established or designated under paragraph (1) and the Federal Hospital Council, the National Advisory Health Council, [the Health Insurance Benefits Advisory Council,] and other appropriate national advisory councils with respect to matters bearing on the purposes and administration of this section and the coordination of activities under this section with related Federal health programs.

(3) If an advisory council is established by the Secretary under paragraph (1), it shall be composed of members who are not otherwise in the regular full-time employ of the United States, and who shall be appointed by the Secretary without regard to the civil service laws from among leaders in the fields of the fundamental sciences, the medical sciences, and the organization, delivery, and financing of health

care, and persons who are State or local officials or are active in community affairs or public or civic affairs or who are representative of minority groups. Members of such advisory council, while attending meetings of the council or otherwise serving on business of the council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the maximum rate specified at the time of such service for grade GS–18 in section 5332 of title 5, United States Code, including traveltime, and while away from their homes or regular places of business they may also be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of such title 5 for persons in the Government service employed intermittently.

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HEALTH FACILITIES COSTS COMMISSION

Sec. 1127. *(a) There is established a commission to be known as the Health Facilities Costs Commission (hereinafter in this section referred to as the "Commission").*

(b)(1) The Commission shall be composed of fifteen members appointed by the Secretary—

(A) at least five of whom shall be individuals who are representatives of providers;

(B) at least five of whom shall be individuals who represent public (including Federal, State, and local) health benefit programs; and

(C) the remainder of whom shall be, as a result of training, experience, or attainments, particularly and exceptionally well qualified to assist in serving and carrying out the functions of the Commission.

One of the members of the Commission, at the time of appointment, shall be designated as Chairman of the Commission. The Secretary shall first appoint members to the Commission not later than January 1, 1980.

(2) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

(3) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

(4) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

(5) Members of the Commission shall be appointed for a term of four years, except that the Secretary shall provide for such shorter terms for some of the members first appointed so as to stagger the date of expiration of members' terms of office.

(6) No individual may be appointed to serve more than two terms as a member of the Commission.

(7) Each member of the Commission shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including traveltime) during which the member is engaged in the actual performance of duties vested in the Commission, and all members of the Commission shall be allowed, while away from their homes or regular places of

business in the performance of service for the Commission, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(8) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

(c)(1) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of the reimbursement of hospitals for care provided by them to individuals covered under title XVIII or under State plans approved under title XIX, with particular attention to the criteria established by section 1861 (bb) with a view to devising additional methods for reimbursing hospitals for all other costs, and for reimbursing all other entities which are reimbursed on the basis of reasonable cost. These methods shall provide for appropriate classification and reimbursement systems designed to ordinarily permit comparisons of (A) the cost centers of one entity, either individually or in the aggregate, with cost centers similar in terms of size and scale of operation, (B) prevailing wage levels, (C) the nature, extent, and appropriate volume of the services furnished, and (D) other factors which have a substantial impact on hospital costs. The Commission shall also develop procedures for appropriate exceptions. The Commission shall submit to the Congress reports on its progress in addressing these issues at least once every six months during the three-year period following the date of the enactment of this section.

(2) The Commission shall study appropriate methods for classifying and comparing hospitals which, with respect to any accounting year, derive 75 percent or more (as estimated by the Secretary) of their inpatient care revenues from one or more health maintenance organizations. The Commission shall consider recommending the classification and comparison of such hospitals as a separate category in recognition of the differences in the nature of their operations as compared with other hospitals.

(3)(A) The Secretary, taking account of the proposals and advice of the Commission, shall by regulation make appropriate modifications in the method of reimbursement under titles V, XVIII, and XIX for routine hospital costs, other hospital costs, and costs of other entities which are reimbursed on the basis of reasonable costs.

(B) In any case in which the Secretary proposes to make such modifications, he shall first submit such proposal to the Commission. If the Commission disagrees with such proposal, final regulations implementing such proposal shall be submitted to Congress by the Secretary, and such regulations may not become effective until at least 60 days after they were submitted to Congress.

(d) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Commission may need.

(e) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon re-

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quest of the Chairman of the Commission, any such department or agency shall furnish any such data or information to the Commission.

(f) There are authorized to be appropriated such sums as may be necessary to carry out this section.

(g) Section 14 of the Federal Advisory Committee Act shall not apply to the Commission.

(4) The Commission shall review and make recommendations with respect to a method of classifying and comparing detoxification facilities so as to provide that such method may be used for reimbursement purposes for such facilities within two years after the date of the enactment of this section.

(5) The Commission shall give immediate priority to making a study and submitting recommendations to the Secretary with respect to the setting of limitations on reasonable costs and reasonable charges for outpatient services as provided in section 1134(c).

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

Sec. 1128. *(a) (1) (A) Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the "Board"). The Board shall have five members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, who are knowledgeable about hospital planning and hospital operations.*

(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be appointed for shorter terms to permit staggered terms of office.

(C) Members of the Board shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS–18 under section 5332 of title 5, United States Code.

(D) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Board may need.

(2) The Board shall receive and act upon applications by hospitals, certified for participation (other than as "emergency hospitals") under titles XVIII and XIX, for transitional allowances.

(b) For purposes of this section—

(1) The term "transitional allowance" means an amount which—

(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by titles V, XVIII, and XIX of this Act; and

(B) in accordance with this section, is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

(2) The term "qualified facility conversion" means closing, modifying, or changing the usage of an underutilized hospital

facility which is expected to benefit the programs authorized under title V, title XVIII, and title XIX by (A) eliminating excess bed capacity, (B) discontinuing an underutilized service for which there are adequate alternative sources, or (C) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.

(3) A hospital which has carried out a qualified facility conversion and which continues in operation will be regarded as having experienced a "reimbursement detriment"—

(A) to the extent that, solely because of the conversion, there is a reduction in that portion of the hospital's costs attributable to capital assets which are taken into account in determining reasonable cost for purposes of determining amount of payment to the hopsital under title V, title XVIII, or a State plan approved under title XIX;

(B) if the conversion results, on an interim basis, in increased operating costs, to the extent that operating costs exceed amounts ordinarily reimbursable under title V, title XVIII, and the State plan approved under title XIX; or

(C) in the case of complete closure of a private nonprofit hospital, or local governmental hospital, other than for replacement of the hospital, to the extent of actual debt obligations previously recognized as reasonable for reimbursement, where the debt remains outstanding, less any salvage value.

(c)(1) Any hospital may file an application with the Board (in such form and including such data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which is formally initiated after December 31, 1979. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursment detriment may be made prior to the actual conversion.

(2) The Board shall consider any application filed by a hospital, and if the Board finds that—

(A) the facility conversion is a qualified facility conversion, and

(B) the hospital is experiencing or will experience a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under titles V and XVIII and the State plan approved under title XIX, for a period, not to exceed twenty years as specified by the Board, and, if the Board finds that the criteria in subparagraphs (A) and (B) are not met, it shall advise the Secretary not to establish a transitional allowance for that hospital. For an approved closure under subsection (b)(3)(C) the Board may recommend or the Secretary may approve, a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

(3)(A) The Board shall notify a hospital of its findings and recommendations.

(B) A hospital dissatisfied with a recommendation may obtain an informal or formal hearing, at the discretion of the Secretary by filing (in the form and within a time period established by the Secretary) a request for a hearing.

(4)(A) Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing, the Secretary shall make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.

(B) The Secretary shall notify a hospital and any other appropriate parties of the determination.

(C) Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this Act, except that the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861(v)(1) and section 1861(bb) of this Act, or in determining the amount to be paid to a provider pursuant to section 1814(b), section 1833(a)(2), section 1903(i)(3), and section 506(f)(3) of this Act.

(d) In determining the reasonable cost incurred by a hospital with respect to which payment is authoized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.

(e)(1) The Secretary is authorized to establish transitional allowances only as provided in paragraphs (2) and (3).

(2) Prior to January 1, 1983, the Secretary is authorized to establish a transitional allowance for not more than fifty hospitals.

(3) On and after January 1, 1983, the Secretary is authorized to establish a transitional allowance for any hospital which qualifies for such an allowance under the provisions of this section.

(4) On or before January 1, 1982, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations.

Coordinated Audits

Sec. 1129. *If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall apportion to the program established under title V or XIX that part of the cost of coordinated audits which is attributable to each such program and which would not have otherwise been incurred in an audit of the*

program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be the amount that represents the duplication of costs resulting from such State's failure to participate in the common audit.

Encouragement of Philanthropic Support for Health Care

Sec. 1130. *(a) It is the policy of the Congress that philanthropic support for health care be encouraged and expanded, especially in support of experimental and innovative efforts to improve the health care delivery system and access to health care services.*

(b)(1) For purposes of determining, under title XVIII or XIX, the reasonable costs of any service furnished by a provider of health services—

(A) except as provided in paragraph (2), unrestricted grants, gifts, and endowments and income therefrom, shall not be deducted from the operating costs of such provider, and

(B) grants, gifts, and endowment income designated by a donor for paying specific operating costs of such provider shall be deducted from the particular operating costs or group of costs involved.

(2) Income from endowments and investments may be used to reduce interest expense, if such income is from an unrestricted gift or grant and is commingled with other funds, except that in no event shall any such interest expense be reduced below zero by any such income.

Grants and Loans for Conversion to Long-Term Care Facility

Sec. 1132. *(a) The Secretary is authorized to carry out a program of grants and loans to facilitate the conversion of surplus acute care hospital beds to long-term care beds in public and nonprofit hospitals. The purpose of such program is to alleviate the problem of patients being provided inpatient hospital services in circumstances under which medically appropriate care could be provided in a less costly facility.*

(b) In carrying out the provisions of this section the Secretary shall give priority to hospitals located in high cost urban areas, and to total conversions of public hospitals to extended care facilities.

(c)(1) There are authorized to be appropriated, over the 2-year period consisting of fiscal years 1980 and 1981, $100,000,000 for the purpose of making grants and loans under this section, not more than $50,000,000 of which may be used for making grants.

(2) The Secretary may make grants under this section for conversions in amounts up to that portion of the conversion cost which equals the average portion of the hospital's patients in the last two full accounting years preceding the conversion who were beneficiaries under title XVIII or a State plan approved under title XIX of this Act.

(3) The Secretary may make loans under this section for conversions in amounts up to the remainder of the conversion cost not covered by a grant made under this section or a grant or loan made under any other Federal program. Such loans shall be made from the Federal

Hospital Insurance Trust Fund at a rate of interest equal to the interest rate at the time of such loan on obligations issued for purchase by such trust fund, plus 1 percent.

(d) In carrying out this section the Secretary shall insure that—

(1) grants and loans under this section are coordinated with similar aid provided under Federal law, and with the actions of the Hospital Transitional Allowance Board taken under section 1128; and

(2) regulations and exceptions with respect to conditions of participation shall be promulgated which allow, to the maximum extent feasible, for ease and simplicity in converting from acute care hospital beds to long-term care beds where the health and safety of patients is not jeopardized.

(e) Long-term care beds created by a conversion carried out under this section may be reconverted to acute care hospital beds within the two-year period following such conversion without being subject to the provisions of section 1122 of this Act.

Use of Approved Relative Value Schedule

Sec. 1133. *(a) To provide common language describing the various kinds and levels of medical services which may be reimbursed under titles V, XVIII, and XIX of this Act, the Secretary shall establish a system of procedural terminology, including definitions of terms. The system shall be developed by the Health Care Financing Administration with the advice of other large health care purchasers, representatives of professional groups and other interested parties. In developing the system, the Health Care Financing Administration shall consider among other things, the experience of third parties in using existing terminology systems in terms of implications for administrative and program costs, simplicity and lack of ambiguity, and the degree of acceptance and use.*

(b) Upon development of a proposed system of procedural terminology and its approval by the Secretary the system shall be published in the Federal Register. Interested parties shall have not less than six months in which to comment on the proposed system and to recommend relative values to the Secretary for the procedures and services designated by the terms. Comments and proposals shall be supported by information and documentation specified by the Secretary.

(c) The good faith preparation of a relative value schedule or its submission to the Secretary by an association of health practitioners solely in response to a request of the Secretary as authorized under this section shall not in itself be considered a violation of any consent decree by which an association has waived its right to make recommendations concerning fees. The proposed relative value schedule shall not be disclosed to anyone other than those persons actually preparing it or their counsel until it is made public by the Secretary.

(d) The Health Care Financing Administration shall review materials submitted under this section and shall recommend that the Secretary adopt a specific terminology system and its relative values for use by carriers in calculating reasonable charges under title XVIII of this Act, but only after—

(1) interested parties have been given an opportunity to comment and any comments have been considered;

(2) statistical analyses have been conducted assessing the economic impact of the relative values on the physicians in various specialties, geographic areas and types of practice, and on the potential liability of the program established by part B of title XVIII of this Act;

(3) it has been determined that the proposed terminology and related definitions are unambiguous, practical, and easy to evaluate in actual clinical situations and that the unit values assigned generally reflect the relative time and effort consistent with the inherent complexity of the procedures and services, required to perform various procedures and services; and

(4) it has been determined that the use of the proposed system will enhance the administration of the Federal health care financing programs.

(e) A system of terminology, definitions, and their relative values, as approved by the Secretary, shall be periodically reviewed by him and may be modified. An approved system (as amended by any modification of the Secretary) may subsequently be used by any organization or person for purposes other than those of this Act.

(f) Nothing in this section shall be considered to bar the Secretary from adopting a uniform systems of procedural terminology in situations where a relative value schedule has not been approved.

Exclusion of Certain Items in Determining Reasonable Cost and Reasonable Charge

Sec. 1134. (a) Except as otherwise provided in subsection (b), in determining the amount of any payment under title XVIII, under a program established under title V, or under a State plan approved under title XIX of this Act, when the payment is based upon the reasonable cost or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if, and to the extent that, such element is—

(1) a commission, finder's fee, or for a similar arrangement, or

(2) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement,

which is, directly or indirectly, determined, wholly or in part as a percentage, fraction, or portion of the charge or cost attributed to any health service (other than the element) or any health service including, but not limited to the element.

(b)(1) The Secretary shall by regulations establish exceptions to the provisions of subsection (a) with respect to any element of cost or charge which consists of payments based on a percentage arrangement, if such element is otherwise reasonable and the percentage arrangement—

(A) is a customary commercial business practice, or

(B) provides incentives for the efficient and economical operation of the health service.

(2) The provisions of subsection (a) shall not be applicable to compensation payable to a physician under a percentage arrangement (in-

cluding an arrangement that relates to compensation for supervisory, executive, eductional, or research activity) between a physician and a hospital if the physician shows (to the satisfaction of the Secretary) that compensation under such arrangement does not exceed, on an annual basis, an amount which would reasonably have been paid to the physician under a relative value schedule approved by the Secretary under section 1133 and which takes into consideration such physician's' time and effort consistent with the inherent complexity of the procedures and services.

(c) The Secretary shall issue regulations that provide for the establishment of limitations on the amount of any costs or charges that shall be considered reasonable with respect to services provided on an outpatient basis by hospitals, community health centers, or clinics (other than rural health clinics), which are reimbursed on a cost basis or on the basis of cost related charges, and by physicians utilizing such outpatient facilities. Such limitations shall be based upon the reasonableness of such costs or charges in relation to the reasonable charges of physicians in the same area for similar services provided in their offices.

Development of Uniform Claims Forms

Sec. 1135. *(a) Within the two-year period commencing on the date of the enactment of this section, the Secretary shall, to the maximum extent feasible, develop and require to be employed, in the administration of the health insurance for the aged and disabled program established by title XVIII and the medical assistance programs approved under title XIX, uniform claims forms which shall be utilized in making payment for health services under such programs. Such claims forms may vary in form and content, but only to the extent clearly required.*

(b) The Secretary shall require forms developed pursuant to subsection (a) to be utilized in the administration of health care programs (other than those referred to in subsection (a)) over which he has administrative responsibility, if he determines that such use is in the interest of effective administration of such programs.

(c) The Secretary, in carrying out the provisions of subsection (a), shall consult with those charged with the administration of Federal programs (other than those referred to in subsections (a) and (b)) and with other organizations and persons that pay for health care, and with the concerned providers of health care services, with the objective of having a broad representation of such programs and plans to facilitate and encourage maximum use by other programs of such uniform claims forms.

Notification to State Officials

Sec. 1136. *If the Secretary notifies a State of any audit, quality control performance report, deficiency, or any reduction, termination, or increase in Federal matching, under the State plan for any program for which Federal payments are made under this Act, simultaneous notification shall also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the program affected.*

Appointment of the Administrator of the Health Care Financing Administration

Sec. 1137. *The Administrator of the Health Care Financing Administration shall be appointed by the President, by and with the advice and consent of the Senate.*

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PART B—PROFESSIONAL STANDARDS REVIEW

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Duties and Functions of Professional Standards Review Organizations

Sec. 1155. (a) (1) Notwithstanding any other provision of law, but consistent with the provisions of this part, it shall be the duty and function of each Professional Standards Review Organization for any area to assume, at the earliest date practicable, responsibility for the review of the professional activities in such area of physicians and other health care practitioners and institutional and noninstitutional providers of health care services (except as provided in paragraph (7)) in the provision of health care services and items for which payment may be made (in whole or in part) under this Act for the purpose of determining whether—

(A) such services and items are or were medically necessary;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could, consistent with the provision of appropriate medical care, be effectively provided on an outpatient basis or more economically in an inpatient health care facility of a different type.

In carrying out the provisions of this paragraph such organization shall give priority to making such determinations with respect to routine hospital admission testing preoperative hospital stays in excess of one day and elective admissions on weekends or other times when services are not available.

(2) Each professional Standards Review Organization shall have the authority to determine, in advance, in the case of—

(A) any elective admission to a hospital, or other health care facility, or

(B) any other health care service which will consist of extended or costly courses of treatment,

whether such service, if provided, or if provided by a particular health care practioner or by a particular hospital or other health care facility, organization, or agency, would meet the criteria specified in clauses (A) and (C) of paragraph (1).

(3) Each Professional Standards Review Organization shall, in accordance with regulations of the Secretary, determine and publish, from time to time, the types and kinds of cases (whether by type of health care or diagnosis involved, or whether in terms of other relevant criteria relating to the provision of health care services) with

respect to which such organization will, in order most effectively to carry out the purposes of this part, exercise the authority conferred upon it under paragraph (2).

(4) Each Professional Standards Review Organization shall be responsible for the arranging for the maintenance of and the regular review of profiles of care and services received and provided with respect to patients, utilizing to the greatest extent practicable in such patient profiles, methods of coding which will provide maximum confidentiality as to patient identity and assure objective evaluation consistent with the purposes of this part. Profiles shall also be regularly reviewed on an ongoing basis with respect to each health care practitioner and provider to determine whether the care and services ordered or rendered are consistent with the criteria specified in clauses (A), (B), and (C) of paragraph (1).

(5) Physicians assigned responsibility for the review of hospital care may be only those having active hospital staff privileges in at least one of the participating hospitals in the area served by the Professional Standards Review Organization.

(6) No physician shall be permitted to review—

(A) health care services provided to a patient if he was directly responsible for providing such services, or

(B) health care services provided in or by an institution, organization, or agency, if he or any member of his family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

For purposes of this paragraph, a physician's family includes only his spouse (other than a spouse who is legally separated from him under a decree of divorce or separate maintenance), children (including legally adopted children), grandchildren, parents, and grandparents.

(7)(A) Except as provided in subparagraph (B), a Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities (as defined in section 1905(c)) and in public institutions for the mentally retarded (described in section 1905(d)(1)) only if (i) the Secretary finds, on the basis of such documentation as he may require from the State, that the single State agency which administers or supervises the administration of the State plan approved under title XIX for that State is not performing effective review of the quality and necessity of health care services provided in such facilities and institutions, or (ii) the State requests such organization to assume such responsibility.

(B) A Professional Standards Review Organization located in a State has the function and duty to assume responsibility for the review under paragraph (1) of professional activities in intermediate care facilities in the State that are also skilled nursing facilities (as defined in section 1861(j)), to the extent that the Secretary finds that the performance of such function by the single State agency (described in subparagraph (A)) for that State is inefficient.

(b) To the extent necessary or appropriate for the proper performance of its duties and functions, the Professional Standards Review Organization serving any area is authorized in accordance with regulations prescribed by the Secretary to—

(1) make arrangements to utilize the services of persons who are practitioners of or specialists in the various areas of medicine (including dentistry), or other types of health care, which persons shall, to the maximum extent practicable, be individuals engaged in the practice of their profession within the area served by such organization, *and such organization shall provide that the services of such persons who hold independent hospital admitting privileges shall be utilized for purposes of formal participation in the review of institutional services provided by such persons;*

(2) undertake such professional inquiry either before or after, or both before and after, the provision of services with respect to which such organization has a responsibility for review under subsection (a) (1);

(3) examine the pertinent records of any practitioner or provider of health care services providing services with respect to which such organization has a responsibility for review under subsection (a) (1); and

(4) inspect the facilities in which care is rendered or services provided (which are located in such area) of any practitioner or provider.

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(*h*) *Any Professional Standards Review Organization which has assumed responsibility under this section for review of inpatient hospital services in an area shall also assume responsibility in such area for review of detoxification facility services.*

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Requirement of Review Approval as Condition of Payment of Claims

Sec. 1158. (a) Except as provided for in section 1159 and [subsection (d)] *subsections* (*d*) *and* (*e*), no Federal funds appropriated under any title of this Act (other than title V) for the provision of health care services or items shall be used (directly or indirectly) for the payment, under such title or any program established pursuant thereto, of any claim for the provision of such services or items, unless the Secretary, pursuant to regulation determines that the claimant is without fault if—

(1) the provision of such services or items is subject to review under this part by any Professional Standards Review Organization, or other agency; and

(2) such organization or other agency has, in the proper exercise of its duties and functions under or consistent with the purposes of this part, disapproved of the services or items giving rise to such claim, and has notified the practitioner or provider who provided or proposed to provide such services or items and the individual who would receive or was proposed to receive such services or items of its disapproval of the provision of such services or items.

* * * * * * *

(d) [In any case] (*1*) *Except as provided in subsection* (*e*) *and paragraph* (*2*) *of this subsection, in any case* in which a Professional

Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services or posthospital extended care services, payment may be made for such services furnished before the second day after the day on which the provider received notice of such disapproval, or, if such organization determines that more time is required in order to arrange postdischarge care, payment may be made for such services furnished before the fourth day after the day on which the provider received notice of such disapproval.

(2) A Professional Standards Review Organization shall not disapprove (under subsection (a)) of inpatient hospital services provided under a title of this Act to an individual on the grounds that such individual could receive appropriate medical care more economically in an inpatient facility of another type for which payment can be made under such title if—

(A) there is no excess of inpatient hospital beds in the geographic area in which the hospital is located (as certified by the State or local health planning agency or health systems agency); and

(B) there is no such other type of facility available to such individual to provide appropriate care for which payment can be made under such title.

(e)(1) If, for purposes of payment under a title of this Act as described in subsection (a) the Professional Standards Review Organization disapproves (under subsection (a)) of inpatient hospital services provided by a hospital to an individual on the grounds that such individual could receive appropriate medical care more economically in an inpatient facility of another type, and such organization finds that—

(A) payment is authorized to be made under or pursuant to such title of this Act (as described in subsection (a)) with respect to services furnished to such individual in such other type of facility; and

(B) there is no such other type of facility available to such individual,

then payment, from funds described in subsection (a), to such hospital may continue to be made (but at a rate determined under paragraph (2)) for days (in a continuous period of days which begins with the day following the last day for which payment may be made, with application of subsection (d), for such inpatient hospital services furnished to such individual) with respect to which such individual meets the conditions specified in subparagraphs (A) and (B).

(2)(A) The rate at which payment may be continued under paragraph (1) shall be a rate equal to the estimated average rate per patient-day paid for services provided in such other type of facility under the State plan approved under title XIX of the State in which such hospital is located, or, if less, the rate in effect for such hospital for services of the type provided in such other type of facility (if such hospital has a unit which provides such other type of services).

(B) In the case of a State that does not have a State plan approved under title XIX, the rate at which payment may be continued under paragraph (1) shall be a rate equal to the estimated average rate per patient-day for services provided in such other type of facility under title XVIII in the State in which such hopsital is located, or, if less,

the rate in effect for such hopsital for services of the type provided in such other type of facility (if such hospital has a unit which provides such other type of services).

(3) Any day on which an individual receives inpatient hospital services for which payment is made at a lower rate on account of the provisions of this subsection shall, for purposes of this Act, be deemed to be a day on which he received the type of services provided by such other type of facility.

* * * * * * *

National Professional Standards Review Council

Sec. 1163. (a) (1) There shall be established a National Professional Standards Review Council (hereinafter in this section referred to as the "Council") which shall consist of eleven physicians, *one doctor of dental surgery or of dental medicine, and one registered nurse*, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service.

(2) Members of the Council shall be appointed for a term of three years, except that the Secretary may provide, in the case of any terms scheduled to expire after January 1, 1978, for such shorter terms as will ensure that (on a continuing basis) the terms of no more than [four] *five* members expire in any year. Members of the Council shall be eligible for reappointment.

(3) The Secretary shall from time to time designate one of the *physician* members of the Council to serve as Chairman thereof.

(b) [Members] *Physician members* of the Council shall consist of physicians of recognized standing and distinction in the appraisal of medical practice. A majority of such members shall be physicians who have been recommended by the Secretary to serve on the Council by national organizations recognized by the Secretary as representing practicing physicians. The membership of the Council shall include physicians who have been recommended for membership on the Council by consumer groups and other health care interests. *The non-physician members of the Council shall be practitioners of recognized standing and distinction in the reviewing of dental or nursing care (as the case may be).*

* * * * * * *

Prohibition Against Disclosure of Information

[**Sec. 1166.** (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part, (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or (3) in accordance with subsection (b).]

Sec. 1166. *(a) Any data or information acquired by any Professional Standards Review Organization in the exercise of its duties and*

functions, which data or information was not publicly available at the time acquired, which identifies (by name or inference) an individual patient, practitioner, provider (other than aggregated statistical information with respect to providers), supplier, or reviewer, shall be held in confidence and shall not be disclosed to any person except—

(1) in accordance with subsection (b); or

(2) to the extent that may be necessary to carry out the purposes of this part, in such cases and under such circumstances as the Secretary shall provide by regulations (which regulations shall assure adequate protection of the rights and interests of patients, health care practitioners, and providers of health care) to: the Secretary, the General Accounting Office, claims payments agencies, public agencies responsible for monitoring or auditing claims, medical review boards for renal disease network areas (established under section 1881). State and local public health officials, researchers and statistical agencies, courts, organizations providing specified services to the Professional Standards Review Organization, other Professional Standards Review Organizations, Statewide Professional Standards Review Councils, institutions or practitioners within the Professional Standards Review Organization, entities recognized by the Secretary as having licensing, accreditation, or certification functions with respect to health care, or entities so identified as having monitoring functions with respect to Professional Standards Review Organizations as provided by law, or to, or with the consent of, the patient, practitioner or provider with respect to whom the information is disclosed.

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Medical Officers in American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands To Be Included in the Professional Standards Review Program

Sec. 1173. For purposes of applying this part [(except sections 1155(c) and 1163)] *(except section 1155(c))* to American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands, individuals licensed to practice medicine in those places shall be considered to be physicians and doctors of medicine.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital and related [post-hospital] services in accordance with this part for (1) individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the

railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 consecutive months to benefits under title II of this Act or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; [and]

(3) [post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.] *home health services; and*

(4) detoxification facility services.

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an in-

patient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections (b) [, (c), and (d)] *and (c)*, inpatient hospital services, inpatient psychiatric hospital services, *and* post-hospital extended care services[, and post-hospital home health services] shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

* * * * * * *

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1866 and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year;

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treat-

ment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(B) in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition noncommunicable;

(C) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would consititute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services;

(D) in the case of [post-hospital] home health services[,] (*i*) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and], (*ii*) *a plan for the furnishing of such services has been established and is periodically reviewed by a physician or, in the case of home health services provided in a rural area described in clause* (*i*) *of the second sentence of section 1861*(*aa*)(*2*), *by a physician's assistant or nurse practitioner* (*as defined in section 1861*(*aa*)(*3*)) *who is under the general supervision of a physician, and* (*iii*) such services are or were furnished while the individual was under the care of a physician; [or]

(E) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical

status, *or because of the severity of the dental procedure* requires hospitalization in connection with the provision of such dental services; *or*

(F) in the case of detoxification facility services, such services are required on an inpatient basis (based upon an examination by such certifying physician made prior to initiation of detoxification);

(3) with respect to inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services) which are furnished over a period of time, a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purposes, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulations, and (B) the first such certification required in accordance with clause (A) shall be furnished no later than the 20th day of such period;

(4) in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services;

(5) in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable;

(6) with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such a day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or skilled nursing facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and

(7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization to review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), (D), or (E) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

* * * * * * *

No Payments to Federal Providers of Services

(c) Subject to section 1880. no payment may be made under this part (except under subsection (d) or subsection [(j)] (*h*)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.

* * * * * * *

[Payment for Posthospital Extended Care Services

[(h) (1) An individual shall be presumed to require the care specified in subsection (a) (2) (C) of this section for purposes of making payment to an extended care facility (subject to the provisions of section 1812) for posthospital extended care services which are furnished by such facility to such individual if—

[(A) the certification referred to in subsection (a) (2) (C) of this section is submitted prior to or at the time of admission of such individual to such extended care facility,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations,

[(C) such certification is accompanied by a plan of treatment for providing such services, and

[(D) there is compliance with such other requirements and procedures as may be specified in regulations,

but only for services furnished during such limited periods of time with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum length of stay in an institution generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physician is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply, after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A), (B), or (C) of paragraph (1).

[Payment for Posthospital Home Health Services

[(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for posthospital home health services furnished by such agency to such individual if—

[(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

[(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

[(C) there is compliance with such other requirements and procedures may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

[(2) If the Secretary determines with respect to a physician that such physican is submitting with some frequency (A) erroneous certifications that individuals have conditions designated in regulations as provided in this subsection or (B) plans for providing services which are inappropriate, the provisions of paragraph (1) shall not apply after the effective date of such determination, in any case in which such physician submits a certification or plan referred to in subparagraph (A) or (B) of paragraph (1).]

Payment for Certain Hospital Services Provided in Veterans' Administration Hospitals

[(j)](*h*)(1) Payments shall also be made to any hospital operated by the Veterans' Administration for inpatient hospital services furnished in a calendar year by the hospital, or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital benefits under section 226 even though the hospital is a Federal provider of services if (A) the individual was not entitled to have the services furnished to him free of charge by the hospital, (B) the individual was admitted to the hospital in the reasonable belief on the part of the admitting authorities that the individual was a person who was entitled to have the services furnished to him free of charge, (C) the authorities of the hospital, in admitting the individual, and the individual, acted in good faith, and (D) the services were furnished during a period ending with the close of the day on which the authorities operating the hospital first became aware of the fact that the individual was not entitled to have the services furnished to him by the hospital free of charge, or (if later) ending with the first day on which it was medically feasible to remove the individual from the hospital by discharging him therefrom or transferring him to a hospital which has in effect an agreement under this title.

(2) Payment for services described in paragraph (1) shall be in an amount equal to the charge imposed by the Veterans' Administration

for such services, or (if less) the reasonable costs for such services (as estimated by the Secretary). Any such payment shall be made to the entity to which payment for the services involved would have been payable, if payment for such services had been made by the individual receiving the services involved (or by another private person acting on behalf of such individual).

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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Scope of Benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs [(B) and (D)] *(B)*, *(D)*, *(E)*, *and (F)* of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; [and]

(D) rural health clinic services [.] *;*

(E) teaching team services; and

(F) comprehensive outpatient rehabilitation services.

(b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

Payment of Benefits

Sec. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program estab-

lished by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as determined pursuant to subsection (g) of this section), and (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, and

(2) in the case of services described in section 1832(a)(2) (except those services described in [subparagraph (D)] *subparagraphs (D) and (E)* of section 1832(a)(2))—with respect to home health services, 100 percent, and with respect to other services (unless otherwise specified in section 1881), 80 percent of—

(A) the lesser of (i) the reasonable cost of such services, as determined under section 1861(v), or (ii) the customary charges with respect to such services; or

(B) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); or

(C) if such services are services to which the next to last sentence of section 1861(p) applies, the reasonable charges for such services, [and]

(3) in the case of services described in section 1832(a)(2)(D), 80 percent of costs which are reasonable and related to the cost of furnishing such services or on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A)[.], *and*

(4) in the case of services described in section 1832(a)(2)(E), 100 per centum of the reasonable charge for such services.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount

of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology, (*3*) *such total amount shall not include expenses incurred for diagnostic tests with respect to which the provisions of subsection* (*a*) (*1*) (*D*) *are applicable, and* (*4*) *such total shall not include expenses for services described in subparagraph* (*D*) *of section 1832*(*a*) (*2*). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * * * *

[Limitation on Home Health Services

[**Sec. 1834.** (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

Procedure for Payment of Claims of Providers of Services

Sec. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calender months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician *or, in the case of home health services provided in a rural area described in clause (i) of the second sentence of section 1861(aa)(2), by a physician's assistant or nurse practitioner (as defined in section 1861(aa)(3)) who is under the general supervision of a physician*, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(B) in the case of medical and other health services except services described in subparagraphs (B), (C), and (D) of section 1861(s)(2), such services are or were medically required; [and]

(C) in the case of outpatient physical therapy services, (i) such services are or were required because the individual needed physical therapy services, (ii) a plan for furnishing such services has been established, and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established *by a physician or by the speech pathologist providing such services* and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]*; and*

(E) in the case of comprehensive outpatient rehabilitation services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is peri-

odically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B), but only with respect to the furnishing of outpatient physical therapy services (as therein defined).

* * * * * * *

Use of Carriers for Administration of Benefits

Sec. 1842. (a) * * *

(b)(1) * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written re-

quest for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. [In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

[No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated cheelchairs for which payment may be made in accordance with section 1861(c)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after Decem-

ber 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on July 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.]

(4)(A) In determining the reasonable charge for services for purposes of paragraph (3) (including the services of any hospital-associated physicians), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

(B)(i) Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.

(ii) In the case of physician services, the prevailing charge level determined for purposes of clause (i)(II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. Moreover, for any twelve-month period beginning on July 1 of any year (beginning with 1980), no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (E)) for that service.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

(D) The requirement in paragraph (3)(B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(E) The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 50 percent of the customary charges made for similar services in the State during the last preceeding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In States with more than one carrier, the statewide prevailing charge level shall be the weighed average of the fiftieth percentiles of the customary charges of each carrier.

(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—

(i) the service or procedure is performed in an area which the Secretary has designated as a physician shortage area.

(ii) the physician has a regular practice in the physician shortage area,

(iii) the charge does not exceed the prevailing charge level as determined under subparagraph (B), and

(iv) the charge does not exceed the amount generally charged by such physician for similar services.

(G) For additional exclusions from reasonable cost and reasonable charge see section 1134.

[(4)] (5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from

term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] *(6)* No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

* * * * * * *

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. (a) * * *

(i) Any State, which prior to the date of enactment of this subsection—

(A) has not entered into an agreement under the preceding provisions of this section, may enter into such an agreement at any time within the twelve-month period which begins with the month

following the month in which this subsection is enacted, and any such agreement shall conform to the modifications prescribed by the Secretary (as referred to in the third sentence of subsection (b)) and may, at the option of the State, contain any provision authorized under subsections (g) and (h) with respect to modifications of agreements with States entered into under the preceding provisions of this section; or

(B) has entered into an agreement under the preceding provisions of this section which has not been modified pursuant to the authority contained in subsection (g) or (h), may within the twelve-month period which begins with the month following the month in which this subsection is enacted modify such agreement in like manner as if the date referred to in subsections (g)(1) and (h)(1) were the day following the close of such twelve-month period.

* * * * * * *

SPECIAL PROVISIONS RELATING TO CERTAIN SURGICAL AND PREOPERATIVE PROCEDURES PERFORMED ON AN AMBULATORY BASIS

Sec. 1845. *(a) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify those surgical procedures which can be safely and appropriately performed either in a hospital on an inpatient basis or on an ambulatorly basis—*

(1) in a physician's office; or

(2) In an ambulatory surgical center or hospital.

(b)(1) If a physician performs in his office a surgical procedure specified by the Secretary pursuant to subsection (a)(1) on an individual insured for benefits under this part, he shall, notwithstanding any other provision of this part, be entitled to have payment made under this part equal to—

(A) 100 percent of the reasonable charge for the services involved with the performance of such procedure (including all pre- and post-operative physicians' services performed in connection therewith), plus

(B) the amount established by the Secretary pursuant to paragraph (2),

but only if the physician agrees with such individal to be paid on the basis of an assignment under the terms of which the reasonable charge for such services is the full charge therefor.

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(1), an amount established with a view to according recognition to the special costs, in excess of usual overhead, which physicians incur which are attributable to securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and to assuring that the performance of such procedure in the physician's office will involve substantially less total cost than would be involved if the procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure periodically shall be reviewed and revised and may

be adjusted, when appropriate, by the Secretary to take account of varying conditions in different areas.

(c) (1) Payment under this part may be made to an ambulatory surgical center for ambulatory facility services furnished in connection with any surgical procedure, specified by the Secretary pursuant to subsection (a) (2), which is performed on an individual insured for benefits under this part in an ambulatory surgical center, which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, if such surgical center agrees to accept, in full payment of all services furnished by it in connection with such procedure, the amount established for such procedure pursuant to paragraph (2).

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a) (2), a reimbursement amount which is payable to an ambulatory surgical center for its services furnished in connection with such procedure. The amount established for any such surgical procedure shall be established with a view to according recognition to the costs incurred by such centers generally in providing the services involved in connection with such procedure, and to assuring that the performance of such procedure in such a center involves less cost than would be involved if such procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(3) If the physician, performing a surgical procedure (specified by the Secretary under subsection (a) (2)), in a hospital on an outpatient basis or in an ambulatory surgical center with respect to which payment is authorized under the preceding provisions of this subsection, or a physician performing physicians' services in such center or hospital directly related to such surgical procedure, agrees to accept as full payment for all services performed by him in connection with such procedure (including pre- and post-operative services) an amount equal to 100 percent of the reasonable charge for such services, he shall be paid under this part for such services an amount equal to 100 percent of the reasonable charge for such services.

(d) (1) The Secretary is authorized by regulations to provide that in case a surgical procedure specified by the Secretary pursuant to subsection (a) (2) is performed on an individual insured for benefits under this part in an ambulatory surgical center which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, there shall be paid with respect to the services furnished by such center and with respect to all related services (including physicians' services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to paragraph (2), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(2) In implementing this subsection, the Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a) (2) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so estab-

lished with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(e) (1) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify those preoperative medical and other health services which can be safely and appropriately performed in a hospital on both an inpatient and outpatient basis.

(2) If a physician, performing a preoperative service (specified by the Secretary under paragraph (1)) in a hospital on an outpatient basis, within seven days prior to admission on an inpatient basis for the surgery to which such service relates, agrees to accept as full payment for such service an amount equal to 100 percent of the reasonable charge for such service, he shall be paid under this part for such service an amount equal to 100 percent of the reasonable charge for such service.

(f) The provisions of sections 1833 (a) and (b) shall not be applicable to expenses attributable to services to which subsection (b) is applicable, to ambulatory facility services (furnished by an ambulatory surgical center) to which the provisions of subsections (c) (1) and (2) are applicable, or to services to which the provisions of subsection (c) (3), (d), or (e) are applicable.

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f) and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and [subsections (i) and (n)] *subsection (i)* of this section) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnoses, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff or physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times except that until January 1, 1979, the Secretary is authorized to waive the requirement of this paragraph for any one-year period with respect to any institution, insofar as such requirement relates to the provision of twenty-four-hour nursing service rendered or

supervised by a registered professional nurse (except that in any event a registered professional nurse must be present on the premises to render or supervise the nursing service provided, during at least the regular daytime shift), where immediately preceding such one-year period he finds that—

(A) such institution is located in a rural area and the supply of hospital services in such area is not sufficient to meet the needs of individuals residing therein,

(B) the failure of such institution to qualify as a hospital would seriously reduce the availability of such services to such individual, and

(C) such institution has made and continues to make a good faith effort to comply with this paragraph, but such compliance is impeded by the lack of qualified nursing personnel in such area;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k);

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing;

(8) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(9) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of the individuals who are furnished services in the institution.

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and [subsections (i) and (n)] *subsection (i)* of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r) to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a

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tuberculosis hospital (as defined in subsection (g)) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. *The term "hospital" also includes a facility of 50 beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—*

(A) with respect to the requirements for nursing services applicable after December 31, 1978, such requirements shall provide for temporary waiver of the requirements, for such period as the Secretary deems appropriate, where (i) the facility's failure to fully comply with the requirements is attributable to a temporary shortage of qualified nursing personnel in the area in which the facility is located, (ii) a registered professional nurse is present on the premises to render or supervise the nursing service provided during at least the regular daytime shift, and (iii) the Secretary determines that the employment of such nursing personnel as are available to the facility during such temporary period will not adversely affect the health and safety of patients;

(B) with respect to the health and safety requirements promulgated under paragraph (9), such requirements shall be applied by the Secretary to a facility herein defined in such manner as to assure that personnel requirements take into account the availability of technical personnel and the educational opportunities for technical personnel in the area in which such facility is located, and the scope of services rendered by such a facility; and the Secretary, by regulations, shall provide for the continued participation of such a facility where such personnel requirements are not fully met, for such period as the Secretary determines that (i) the facility is making good faith efforts to fully comply with the personnel requirements, and (ii) the employment by the facility of such personnel as are available to the facility will not adversely affect the health and safety of patients: Provided, That the facility complies with any determination by the Secretary that the scope of services of such facility should be limited, because failure to so limit, in conjunction with the application of the requirements of this subparagraph, would adversely affect the health and safety of the patients; and

(C) with respect to the fire and safety requirements promulgated under paragraph (9), the Secretary may (i) waive, for such period as he deems appropriate, specific provisions of such require-

ments which if rigidly applied would result in unreasonable hardship for such a facility and which, if not applied, would not jeopardize the health and safety of patients, and (ii) may accept a facility's compliance with all applicable State codes relating to fire and safety in lieu of compliance with the fire and safety requirements promulgated under paragraph (9), if he determines that such State has in effect fire and safety codes, imposed by State law, which adequately protect patients.

* * * * * * *

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2) *and except as provided in subsection (dd)*) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4)(A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing;

(10) has in effect an overall plan and budget that meets the requirements of subsection (z);

(11) complies with the requirements of section 1124;

(12) cooperates in an effective program which provides for a regular program of independent medical evaluation and audit of the patients in the facility to the extent required by the programs in which the facility participates (including medical evaluation of each patient's need for skilled nursing facility care);

(13) meets such provisions of the Life Safety Code of the National Fire Protection Association (23d edition, 1973) as are applicable to nursing homes; except that the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a nursing home, but only if such waiver will not adversely affect the health and safety of the patients; except that the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects patients in nursing facilities;

(14) establishes and maintains a system that (A) assures a full and complete accounting of its patients' personal funds, and (B) includes the use of such separate account for such funds as will preclude any commingling of such funds with facility funds or with the funds of any person other than another such patient; and

(15) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863), except that the Secretary shall not require as a condition of participation that medical social services be furnished in any such institution. Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this subsection to be filed with the Secretary shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under titles XVIII and XIX of this Act;

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2) such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

Utilization Review

(k) A utilization review plan of a hospital or skilled nursing facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians (*of which at least two must be physicians described in subsection 1861(r)(1) of this section*), with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and skilled nursing facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or skilled nursing facility where, because of the small size of the institution, or (in the case of a skilled nursing facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection. If the Secretary deter-

mines that the utilization review procedures established pursuant to title XIX are superior in their effectiveness to the procedures required under this section, he may, to the extent that he deems it appropriate, require for purposes of this title that the procedures established pursuant to title XIX be utilized instead of the procedures required by this section.

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician *or, in the case of home health services provided in a rural area described in clause (i) of the second sentence of subsection (aa) (2), by a physician's assistant, or nurse practitioner (as defined in subsection (aa) (3)) who is under the general supervision of a physician,* which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a *homemaker*-home health aide;

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A), but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *In establishing the plan required by this subsection the physician (or physician's assistant or nurse practitioner) shall include a program*

of patient education aimed at achieving (to the maximum extent feasible) independence for the individual from the need for care provided by other persons. For purposes of this subsection any of the foregoing items and services which are provided to an individual who is not able to leave his place of residence without the assistance of another person shall be deemed to be provided in a place of residence used as such individual's home, if provided, under arrangements made by the home health agency, at a non-profit adult day care center which meets such standards as may be prescribed in regulations by the Secretary; but only if such adult day care center is eligible to participate in a program for which funds are received under title XX of this Act, is designated by the State as an adult day care center for purposes of such title XX, and has a physical plant which meets all applicable State and local safety, sanitation, and fire regulations and building codes and ordinances.

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under Part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

* * * * * * *

Physician

(r) The term "physician," when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), [(2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act.] *(2) a doctor of dental medicine or dental surgery who is legally authorized to practice dentistry by the State in which he performs such function, but only with respect to (A) a function (i) which he is legally authorized to perform as such by the State in which he performs such function, and (ii) which, if performed by an individual described in clause (1), would constitute physicians' services, or (B) the certification required by section 1814(a)(2)(E) of this Act.* [(3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to func-

tions which he is legally authorized to perform as such by the State in which he performs them,] *(3) a doctor of podiatry or surgical chiropody or podiatric medicine for the purposes of subsection (s) of this section but only (unless clause (1) of this subsection also applies to him) with respect to functions which he is legally authorized to perform as such by the State in which he performs them; and for the purposes of subsections (k) and (m) of this section and sections 1814 (a) and 1835, but only if his performance of functions under subsections (k) and (m) and sections 1814(a) and 1835 is consistent with the policy of the institution or agency with respect to which he performs them and with the functions which he is legally authorized to perform*, or (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to establishing the necessity for prosthetic lenses, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray *or other chiropractic clinical findings* to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1)(*A*) physicians' services, *and* (*B*) *any function performed by a doctor of optometry (as described in subsection (r)(4)) with respect to aphakia which he is legally authorized to perform as such by the State in which he performs such function (and payment for the performance of such function under this title shall be made in like manner and under the same conditions as if the performance of such service constituted professional services performed by a physician);*

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis services, and institutional dialysis services and supplies;

(G) teaching team services; and

(H) antigens (subject to reasonable quantity limitations determined by the Secretary) prepared by an allergist for a particular patient, including antigens he prepares which are forwarded to another qualified person for administration to the patient by or under the supervision of a physician (including supervision provided under an arrangement between a physician and a rural health clinic as defined in subsection (aa));

(3) diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary), diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for a reduction of fractures and dislocations;

(6) durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased;

(7) ambulance service (*including ambulance service to the nearest hospital which is (A) adequately equipped, and (B) has medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury, or condition*) where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care) including replacement of such devices; and

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office, a rural health clinic, or a hospital (which, for

purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which—

(12) would not be included under subsection (b) if it were furnished to an inpatient of a hospital; or

(13) is furnished under arrangements referred to in such paragraph (2)(C) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.

None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

* * * * * * *

Provider of Services

(u) The term "provider of services" means a hospital, skilled nursing facility, *comprehensive outpatient rehabilitation facility*, home health agency, *detoxification facility*, or, for purposes of section 1814(g) and section 1835(e), a fund.

Reasonable Cost

(v)(1)(A) [The] *Subject to subsection (bb), the* reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in

computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of *a hospital or* extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed [one and one-half times] *the percentages, specified in the next sentence, of* the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. *For hospital and skilled nursing facility accounting years beginning before July 1, 1980, the percentage referred to in the previous sentence is 150 percent and for subsequent accounting years, the percentage is—*

(i) 150 percent with respect to a skilled nursing facility;

(ii) 150 percent with respect to a hospital which, during such accounting year, has actual routine operating costs which were greater than the maximum allowable routine operating costs of such hospital as determined under section 1861(bb)(4)(B)(i);

(iii) 250 percent with respect to a hospital which, during such accounting year had actual routine operating costs which were less than the hospital's adjusted per diem target rate for routine operating costs as determined under section 1861(bb)(4); and

(iv) 200 percent with respect to other hospitals.

(C) Where a hospital has an arrangement with a medical school under which the faculty of such school provides services at such hospital, an amount not in excess of the reasonable cost of such services to the medical school shall be included in determining the reasonable cost to the hospital of furnishing services—

(i) for which payment may be made under part A, but only if

(I) payment for such services as furnished under such arrangement would be made under part A to the hospital had such services been furnished by the hospital, and

(II) such hospital pays to the medical school at least the reasonable cost of such services to the medical school, or

(ii) for which payment may be made under part B, but only if such hospital pays to the medical school at least the reasonable cost of such services to the medical school.

(D) Where (i) physicians furnish services which are either inpatient hospital services (including services in conjunction with the teaching programs of such hospital) by reason of paragraph (7) of subsection (b) or for which entitlement exists by reason of clause (II) of section 1832(a)(2)(B) (i) and (ii) such hospital (or medical school under arrangement with such hospital) incurs no actual cost in the furnishing of such services, the reasonable cost of such services shall (under regulations of the Secretary) be deemed to be the cost such hospital or medical school would have incurred had it paid a salary to such physicians rendering such services approximately equivalent to the average salary paid to all physicians employed by such hospital (or if such employment does not exist, or is minimal in such hospital, by similar hospitals in a geographic area of sufficient size to assure reasonable inclusion of sufficient physicians in development of such average salary).

(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the uses of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State; except that the foregoing provisions of this subparagraph shall not apply to any skilled nursing facility in such State if—

(i) such facility is a distinct part of or directly operated by a hospital, or

(ii) such facility operates in a close, formal satellite relationship (as defined in regulations of the Secretary) with a participating hospital or hospitals.

Notwithstanding the previous provisions of this paragraph in the case of a facility specified in clause (ii) of this subparagraph, the reasonable cost of any services furnished by such facility as determined by the Secretary under this subsection shall not exceed 150 percent of

the costs determined by the application of this subparagraph (without regard to such clause (ii)).

(F) Such regulations shall require each provider of services (other than a fund) to make reports to the Secretary of information described in section 1121(a) in accordance with the uniform reporting system (established under such section) for that type of provider.

(G) No payment with respect to a cost attributable to the program established by this title shall be made to a provider of services to the extent that such payment exceeds the proportional share of such cost, as measured by days of utilization or provider charges, until such time as evidence can be produced which, in the judgment of the Comptroller General and concurred in by the Secretary, justifies payment of such a higher proportional share as warranted under particular circumstances for certain facilities, and such payments may then be made only to the extent so justified.

Certification and Approval of Skilled Nursing Facilities

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatients psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) If a provider of services furnishes items or services to an individual which are in excess of or more expensive than the items or serv-

ices determined to be necessary in the efficient delivery of needed health services and charges are imposed for such more expensive items or services under the authority granted in section 1866(a)(2)(B)(ii), the amount of payment with respect to such items or services otherwise due such provider in any fiscal period shall be reduced to the extent that such payment plus such charges exceed the cost actually incurred for such items or services in the fiscal period in which such charges are imposed.

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organizations, specified in the first sentence of section 1861(p) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

(B) Notwithstanding the provisions of subparagraph (A), if a provider of services or other organization specified in the first sentence of section 1861(p) requires the services of a therapist on a limited part-time basis, or only to perform intermittent services, the Secretary may make payment on the basis of a reasonable rate per unit of service, even though such rate is greater per unit of time than salary related amounts, where he finds that such greater payment is, in the aggregate, less than the amount that would have been paid if such organization had employed a therapist on a full- or part-time salary basis.

(6) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

(7) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(8) For additional requirements applicable to determination of reasonable cost for services provided by hospitals, see subsection (bb) and section 1127(c)(3).

(9) For additional exclusions from reasonable cost and reasonable charge see section 1134.

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Institutional Planning

[(z) An overall plan and budget of a hospital, extended care facility, or home health agency shall be considered sufficient if it—

(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in excess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

(3) provides for review and updating at least annually; and

(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.]

(z) An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall—

(1) provide for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provide for a capital expenditures plan for at least a five-year period (including the year to which the operating budget applies) which identifies in detail the sources of financing and the objectives of each anticipated expenditure in excess of $150,000 related to the acquisition of land, improvement of land, buildings, or equipment, and the replacement, modernization, or expansion of the buildings and equipment, and which would, under generally accepted accounting principles, be considered capital items, and such capital expenditures plan shall be a matter of public record and available in readily accessible form and fashion;

(3) provide for annual review and updating; and

(4) be prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, administrative staff, and medical staff (if any) of the institution or agency.

* * * * * * *

Criteria for Determining Reasonable Cost of Hospital Services

(bb)(1) It is the purpose of this subsection to set forth initial methods and criteria for determining reimbursement based upon rea-

sonable cost, but such methods and criteria shall be subject to appropriate and expeditious refinement as provided in section 1127. In order more fairly and effectively to determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than April 1, 1980, after consulting with appropriate national organizations, establish a system of hospital classification under which hospitals furnishing services will be classified on a national basis initially—

(A) by size, with each of the following groups of hospitals being classified in separate categories: (i) those having more than 5, but fewer than 25, beds, (ii) those having more than 24, but fewer than 50, beds, (iii) those having more than 49, but fewer than 100, beds, (iv) those having more than 99, but fewer than 200, beds, (v) those having more than 199, but fewer than 300, beds, (vi) those having more than 299, but fewer than 400, beds, (vii) those having more than 399, but fewer than 500, beds, and (viii) those having more than 499 beds;

(B) by type of hospital, with (i) short-term general hospitals being in a separate category, (ii) hospitals which are primary affiliates of accredited medical schools being in one separate category, and (iii) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals;

(C) as rural or urban; and

(D) according to such other criteria as the Secretary finds appropriate, including modification of bed-size categories;

but the system of hospital classification shall not differentiate between hospitals on the basis of ownership.

(2) The term "routine operating costs" used in this subsection does not include—

(A) capital and related costs,

(B) direct personnel and supply costs of approved hospital education and training programs,

(C) costs of interns, residents, and nonadministrative physicians,

(D) energy costs,

(E) malpractice insurance expense, or

(F) ancillary service costs.

(3)(A) During the calendar quarter beginning on January 1 of each year, beginning with 1980, the Secretary shall determine, for the hospitals in each category of the system established under paragraph (1), an average per diem routine operating cost amount which shall (except as otherwise provided in this subsection) be used in determining payments to hospitals.

(B) The determination shall be based upon the amount of the hospitals' routine operating costs for the most recent accounting year ending prior to October 1 of the calendar year preceding the calendar year in which the determination is made. If, for any accounting year which starts on or after July 1, 1980, a hospital's actual routine operating costs are in excess of the amount allowed for purposes of determining payment to the hospital pursuant to this subsection and

subsection (v), only one-half of such excess shall be taken into account in making any determination which the Secretary shall make under this paragraph. Such amount as determined under the preceding sentences of this subparagraph shall be adjusted to reflect the percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of appropriately weighted indicators of changes in the economy in wages and prices which are representative of services and goods included in routine operating costs, during the period from the end of the accounting year referred to in the first sentence of this subparagraph to the end of the quarter in which the determination is being made.

(C) In making a determination, the routine operating costs of hospitals in each category shall be divided into personnel and nonpersonnel components.

(D)(i) The personnel and nonpersonnel components of routine operating costs for hospitals in each category (other than for those excluded under clause (ii)) shall be divided by the total number of days of routine care provided by such hospitals to determine the average per diem routine operating cost for such category.

(ii) In making the calculations required by subparagraph (A) the Secretary shall exclude any newly opened hospital (as defined in the second sentence of paragraph (4)(F)), and any hospital which he determines is experiencing significant cost differentials resulting from failure of the hospital fully to meet the standards and conditions of participation as a provider of services.

(E) There shall be determined for each hospital in each category a per diem target rate for routine operating costs. Such target rate shall equal the average per diem routine operating cost amount for the category in which the hospital is expected to be classified during the subsequent accounting year, except that the personnel component shall be adjusted using a wage index based upon general wage levels for reasonably comparable work in the areas in which the hospitals are located. If the Secretary finds that, in an area where a hospital in any category is located for the most recent twelve-month period for which data with respect to such wage levels are available, the wage level for such hospital is significantly higher than such general wage level in that area (relative to the relationship within the same hospital group between hospital wages and such general wages in other areas), then such general wage level in the area shall be deemed equal to the wage level for such hospital, but only with respect to the hospital's first accounting year beginning on or after July 1, 1980 and prior to July 1, 1981.

(4)(A)(i) The term "adjusted per diem target rate for routine operating costs" means the per diem target rate for routine operating costs plus the percentage increase in costs determined under the succeeding provisions of this subparagraph.

(ii) In determining the adjusted per diem target rate, the Secretary shall add an estimated percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of appropriately weighted indicators of changes in the economy in wages and prices which are representative of services and goods included in

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routine operating costs, during the period from the end of the quarter in which the determination is made under paragraph (3)(A) to the end of the hospital's accounting year. Where actual changes in such weighted index are significantly different (at least one-half of 1 percentage point) from those estimated, the Secretary shall issue corrected target rates on a quarterly basis. At the end of the hospital's accounting year, the target rate shall be adjusted to reflct the actual changes in such weighted index. Adjustments shall also be made to take account of changes in the hospital's classification.

(B) For purposes of payment, the amount of routine operating cost incurred by a hospital for any accounting year which begins on or after July 1, 1980, shall be deemed to be equal—

(i) in the case of a hospital which has actual routine operating costs equal to or greater than that hospital's adjusted per diem target rate for routine operating costs, to the greater of—

(I) the hospital's actual routine operating costs, but not exceeding—

(a) in the case of the first accounting year of any hospital which begins on or after July 1, 1980, and prior to July 1, 1981, an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs, plus (2) 15 percent of the amount described in clause (1), plus (3) one-half of the difference between the hospital's actual routine operating costs and the sum of the amounts determined under clauses (1) and (2),

(b) in the case of the first accounting year of any hospital which begins on or after July 1, 1981, and prior to July 1, 1982 (or if earlier, the second accounting year of such hospital which begins on or after July 1, 1980, and prior to July 1, 1982), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (a)(2) for the category of such hospital, plus (3) one-half of the difference between the hospital's actual routine operating costs and the sum of the amounts determined under clauses (1) and (2), and

(c) in the case of any accounting year after the accounting year described in clause (b), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (b)(2) for the category of such hospital, or

(II) the amount determined for the hospital under division (I) if it had been classified in the bed-size category which contains hospitals closest in bed-size to such hospital's bed-size (with a hospital which has a bed-size that falls halfway between two such categories being considered in the category which contains hospitals with the greater number of beds), but not exceeding the hospital's actual routine operating costs; or

(III) in the case of a hospital having an average length-of-stay per patient which is less than the average length-of-stay per patient for hospitals classified in the same category, for any accounting year, an amount equal to the average reimbursement for routine operating costs per patient stay for hospitals in the same category, multiplied by the number of patient stays for such hospital during that accounting year, but not exceeding the actual routine operating costs for such hospital; and

(ii) in the case of a hospital which has actual routine operating costs which are less than that hospital's adjusted per diem target rate for routine operating costs, to (I) the amount of the hospital's actual routine operating costs, plus (II) the smaller of (a) 5 percent (or 2.5 percent with respect to any accounting year which begins on or after July 1, 1980, and prior to July 1, 1982) of the hospital's adjusted per diem target rate for routine operating costs, or (b) 50 percent (or 25 percent with respect to any accounting year which begins on or after July 1, 1980, and prior to July 1, 1982) of the amount by which the hospital's adjusted per diem target rate for routine operating costs exceeds the hospital's actual routine operating costs.

(C) Any hospital (other than a newly opened hospital) excluded by the Secretary under paragraph (3)(D)(ii), shall be reimbursed for routine operating costs on the basis of the lesser of (i) actual costs or (ii) the reimbursement determined under this subsection.

(D) On or before April 1 of the year in which the Secretary determines the amount of the average per diem operating cost for each hospital category and the adjusted per diem target rate for each hospital, the Secretary shall publish the determinations, and he shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of the determination which affect the hospital.

(E) If a hospital is determined by the Secretary to be—

(i) located in an underserved area where hospital services are not otherwise available,

(ii) certified as being currently necessary by an appropriate planning agency, and

(iii) underutilized,

the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the underutilized capacity.

(F) If a newly opened hospital is determined by the Secretary to have greater routine operating costs as a result of the cost patterns associated with newly opened hospitals, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such patterns. For purposes of this subparagraph a "newly opened hospital" means a hospital which has not satisfied the requirements of paragraphs (1) and (7) of subsection (e) of this section (under present or previous ownership) for at least twenty-four months prior to the start of such hospital's accounting year.

(G) If a hospital is determined by the Secretary to have greater routine operating costs as a result of changes in service on account

of consolidation, sharing, or addition of services, where such consolidation, sharing, or addition has been approved by the appropriate State health planning and development agency or agencies, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such changes in service.

(H)(i) If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than generally is provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the greater intensity of care required.

(ii) To the extent that a hospital can demonstrate that it experiences routine operating costs in excess of such costs for hospitals having a reasonably similar mix of patients on account of consistently shorter lengths-of-stay in such hospital, which result from the greater intensity of care provided by such hospital, the excess routine operating costs shall be considered attributable to the greater intensity of care required, but this clause shall not apply in the case of a hospital whose routine operating costs are determined under subparagraph (B)(i)(III).

(I) The Secretary may further increase the adjusted per diem target rate applicable in Alaska and Hawaii to reflect the higher prices prevailing in such States.

(J) Where the Secretary finds that a hospital has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient services, or that an unusually large proportion of routine nursing service is provided by private-duty nurses, the routine operating costs of that hospital shall be deemed equal to the lesser of (i) the amount determined without regard to this subsection, or (ii) the amount determined under subparagraph (B).

(5) Where any provisions of this subsection are inconsistent with section 1861(v), this subsection supersedes section 1861(v).

(6)(A) Notwithstanding any other provision of this Act, in the case of any State which has established a reimbursement system for hospitals, hospital reimbursement in that State under this title and under the State plan approved under title XIX shall, with respect to the services covered by such system, be based on that State system, if the Secretary finds that—

(i) the State has a reimbursement system and it at least applies to the same hospitals in the State, and to the same costs, as the Federal reimbursement reform program established by this subsection;

(ii) every hospital in the State with which there is a provider agreement under this title or under the State plan approved under title XIX conforms to the accounting and uniform reporting requirements of section 1121 of this Act, and furnishes any appropriate reports that the Secretary may require; and

(iii) such State demonstrates to his satisfaction that the total amount payable, with respect to inpatient hospital costs, in the State under this title and under the State plan approved under

title XIX will be equal to or less than an amount equal to (I) the amount which would otherwise be payable for such costs under this title and such State plan without regard to the incentive payments provided by subparagraph (B)(ii) of paragraph (4) plus (II) the amount of any incentive payments which are allowed under the State's reimbursement system in recognition of demonstrated efficiencies (but not to exceed the amount of the incentive payments which would be allowed under paragraph (4)(B)(ii)).

If the Secretary finds that any of the above conditions in a State which previously met them have not been met for a two-year period, the Secretary shall, after due notice, reimburse hospitals in that State according to the provisions of this Act (other than this paragraph) unless he finds that unusual, justifiable, and nonrecurring circumstances led to the failure to comply.

(B) If the Secretary finds that, during any two-year period during which hospital reimbursement under this title and under the State plan approved under title XIX was based on a State system as provided in subparagraph (A), the amount payable by the Federal Government under such titles for inpatient hospital costs in such State was in excess of the amount which would have been payable for such costs in such State if reimbursement had not been based on the State system (as estimated by the Secretary), the adjusted per diem target rate for routine operating costs (as determined under the preceding paragraphs of this subsection) for hospitals in such State shall be reduced (by not more than 1 percent in any year) until the Federal Government has recouped an amount equal to such excess payment amount.

(C)(i) The Secretary shall pay to any State in which hospital reimbursement under this title is based on a State system as provided in subparagraph (A), an amount which bears the same ratio to the total cost incurred by such State of administering the approved State system (including the cost of initially putting the system into operation) as the amount paid by the Federal Government under this title in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system.

(ii) Payments under clause (i) shall be made from funds in the Federal Hospital Insurance Trust Fund.

(iii) An amount which bears the same ratio to the total cost incurred by such State of administering the approved State system (including the cost of initially putting the system into operation) as the amount paid under the State plan approved under title XIX in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system, shall, for purposes of title XIX, be considered to be an amount expended for the administration of such State plan.

(D) If there is in effect in a State a reimbursement system for hospitals which the Secretary finds meets the criteria prescribed in subparagraph (A) except that such system was not established by the State, at the election of the State, such system shall for purposes of this paragraph be considered to be a reimbursement system for hospitals established by such State.

Detoxification Facility Services

(cc)(1) The term "detoxification facility services" means services provided by a detoxification facility in order to reduce or eliminate the amount of a toxic agent in the body, but only to the extent that such services would be covered under subsection (b) if furnished as an inpatient service by a hospital, or are physician services covered under subsection (s).

(2) The term "detoxification facility" means a public or nonprofit facility, other than a hospital, which—

(A) is engaged in furnishing to inpatients the services described in paragraph (1);

(B) is accredited by the Joint Commission on the Accreditation of Hospitals as meeting the Accreditation Program for Psychiatric Facilities standards (1979 edition), or is found by the Secretary to meet such standards;

(C) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring services not available at the facility; and

(D) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by the facility.

Hospital Providers of Extended Care Services

(dd)(1)(A) Any hospital (other than a hospital which has in effect a waiver under subparagraph (A), (B), or (C) of subsection (e)) which has an agreement under section 1866 may (subject to paragraph (2)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

(B)(i) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this subsection shall be based upon the reasonable cost of the services as determined under this subparagraph.

(ii) The reasonable cost of the services shall consist of the reasonable cost of routine services plus the reasonable cost of ancillary services. The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this subsection shall equal the product of the number of patient-days during the year for which the services were furnished and the average reasonable cost per patient-day. The average reasonable cost per patient-day shall be established as the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) approved under title XIX to skilled nursing facilities located in such State and which meet the requirements specified in section 1902(a)(28), or, in the case a State which does not have such a State plan, the average rate per patient-day paid for routine services during the previous calendar year under this title to skilled nursing facilities in such State. The reasonable cost of ancillary services shall be determined in the same manner as the

reasonable cost of ancillary services is determined in the case of inpatient hospital services.

(2) The Secretary shall not enter into an agreement under this subsection with any hospital unless—

(A) the hospital is located in a rural area and has less than 50 beds, and

(B) the hospital has been granted a certificate of need for the provision of long-term care services from the agency of the State (which has been designated as the State health planning and development agency under an agreement pursuant to section 1521 of the Public Health Service Act) in which the hospital is located.

(3) An agreement with a hospital entered into under this subsection shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866, and shall, where not inconsistent with any provision of this subsection, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in effect an agreement under section 1866, or during which there is in effect for the hospital a waiver of the requirement imposed by subsection (e)(5). A hospital with respect to which an agreement has been terminated shall not be eligible to enter into a new agreement until a two-year period has elapsed from the termination date.

(4) Any agreement with a hospital under this subsection shall provide that payment for services will be made only for services for which payment would be made as posthospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866, and any individual who is furnished services for which payment may be made under an agreement shall, for purposes of this title (other than this subsection), be deemed to have received posthospital extended care services in like manner and to the same extent as if the services furnished to him had been posthospital extended care services furnished by a skilled nursing facility under an agreement under section 1866.

(5) During a period for which a hospital has in effect an agreement under this subsection, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services (including the application of reimbursement limits specified in subsection (bb)), the total reimbursement due for routine services from all classes of long-term care patients, including title XVIII, the State plan approved under title XIX, and private pay patients, shall be subtracted from the hospitals total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(6) During any period during which an agreement is in effect with a hospital under this subsection, the hospital shall, for services furnished by it under the agreement, be considered to satisfy the requirements, otherwise required, of a skilled nursing facility for purposes of the following provisions: sections 1814(a)(2)(C), 1814(a)(6), 1814(a)(7), 1814(h), 1861(a)(2), 1861(i), 1861(j) (except 1861(j)

(12)), and 1861(n); and the Secretary shall specify any other provisions of this Act under which the hospital may be considered as a skilled nursing facility.

(7) The Secretary may enter into an agreement under this subsection on a demonstration basis with any hospital having more than 49 beds, but less than 101 beds, if such hospital otherwise meets the requirements of this subsection.

(8) Within three years after the date of enactment of this subsection, the Secretary shall provide a report to the Congress containing an evaluation of the program established under this subsection concerning—

(A) the effect of the agreements on availability and effective and economical provision of long-term care services;

(B) whether the program should be continued; and

(C) whether eligibility should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

Teaching Team Services

(ee)(1) The term "teaching team" services means physicians' services (as defined in subsection (q) but without regard to the reference therein to subsection (b)(6)) performed by a team (as defined in regulations) which includes a supervising physician and physicians-in-training who are participants (as students or teachers) in a teaching program of a hospital approved as specified in subsection (b)(6), for a private patient (as defined in regulations) of the supervising physician member of such team.

(2) Such term as defined in paragraph (1) shall not include any physician service (whether performed by a physician or by a physician-in-training) in any hospital as a part of or in connection with such a teaching program, unless—

(A) the hospital agrees not to make any claim under this title for reimbursement for or with respect to such services under any provision of this title other than section 1832(a)(2)(E), and then, only in case an agreement between such hospital and such team so provides; and

(B) the teaching teams in such hospital have an agreement with the Secretary under which payments shall be made for such team services only under section 1832(a)(2)(E), and under which the reasonable charge for such services provided shall be accepted as full payment therefor.

Comprehensive Outpatient Rehabilitation Services

(ff)(1) The term "comprehensive outpatient rehabilitation services" means the following items and services furnished by a physician or other qualified professional personnel (as defined in regulations by the Secretary) to an individual who is an outpatient of a comprehensive outpatient rehabilitation facility under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician—

(A) physicians' services;

(B) physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

(C) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(D) social and psychological services;

(E) nursing care provided by or under the supervision of a registered professional nurse;

(F) drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered;

(G) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(H) such other items and services as are medically necessary for the rehabilitation of the patient and are ordinarily furnished by comprehensive outpatient rehabilitation facilities,

excluding, however, any item or service if it would not be included under subsection (s) if furnished to an outpatient of a hospital.

(2) The term "comprehensive outpatient rehabilitation facility" means a public or private institution which—

(A) is primarily engaged in providing (by or under the supervision of physicians) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured, disabled, or sick persons;

(B) provides at least the following comprehensive outpatient rehabilitation services: (i) physicians' services (rendered by physicians, as defined in section 1861(r)(1), who are available at the facility on a full- or part-time basis); (ii) physical therapy, and (iii) social or psychological services;

(C) maintains clinical records on all patients;

(D) has policies established by a group of professional personnel (associated with the facility), including one or more physicians defined in subsection (r)(1) to govern the comprehensive outpatient rehabilitation services it furnishes, and provides for the carrying out of such policies by a full- or part-time physician referred to in subparagraph (B)(i);

(E) has a requirement that every patient must be under the care of a physician;

(F) in the case of a facility in any State in which State or applicable local law provides for the licensing of facilities of this nature (i) is licensed pursuant to such law, or (ii) is approved by the agency of such State or locality, responsible for licensing facilities of this nature, as meeting the standard establishment for such licensing;

(G) has in effect a utilization review plan in accordance with regulations prescribed by the Secretary;

(H) has in effect an overall plan and budget that meets the requirements of subsection (z); and

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities.

Exclusions From Coverage

Sec. 1862. (a) Notwithstanding any other provisions of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

* * * * * * *

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, *or because of the severity of the dental procedure* requires hospitalization in connection with the provision of such services; or

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supporting devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns [, warts,] or calluses, the trimming of nails, and other routine hygienic care).

(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State *or under liability insurance of the person at fault or under no-fault liability insurance.* Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such law or plan, *or under such liability insurance. The Secretary may waive the provisions of this subsection with respect to liability insurance if he determines that the probability of recovery or amount involved does not warrant the pursuing of the claim.*

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Consultation With State Agencies and Other Organizations To Develop Conditions of Participation for Providers of Services

Sec. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e)(9), (f)(4), (g)(4), (j)(11), [and (o)(6)] *(o)(6), and (ff)(2)(I)* of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a

condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2) *or a comprehensive outpatient rehabilitation facility as defined in section 1861(ff)(2)*, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s), or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1861(j). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, rural health clinic, *comprehensive outpatient rehabilitation facility*, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, rural health clinic, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, rural health clinic, laboratory, clinic, agency, or organization.

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable

to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), hospitals which have an agreement with the Secretary under section 1866 and which are accredited by the Joint Commission on the Accreditation of Hospitals. The Secretary shall pay for such services in the manner prescribed in subsection (b).

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Agreements With Providers of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal inter-

mediary or carrier (for purposes of part A or part B, or both, of this) title with respect to the provider[.], *and*

(E) not to increase amounts due from any individual, organization, or agency in order to offset reductions made under section 1861(bb) in the amount paid, or expected to be paid, under this title.

* * * * * * *

(f)(1) If the Secretary determines that—

(A) a skilled nursing facility having an agreement under this section—

(i) is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or

(ii) no longer substantially complies with the provisions of section 1861(j); and

(B) such failure to comply does not jeopardize the health or safety of patients in such facility,

he may, instead of terminating such agreement, impose an intermediate sanction, consisting of a reduction in the amount of reimbursement to be made to such facility under this title or a restriction on the number or kinds of patients for whom reimbursement may be made under this title to such facility, until such time as the failure is corrected.

(2) The Secretary may impose an intermediate sanction under paragraph (1) after giving notice to the facility of his intent to impose the sanction and allowing such facility a reasonable period of time (as determined by the Secretary) in which to correct the failure. Any facility which is dissatisfied with a determination by the Secretary to impose an intermediate sanction upon such facility shall be entitled to a hearing by the Secretary, within 30 days after such sanction is imposed, to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any intermediate sanction imposed by the Secretary shall remain in effect during any period in which a hearing on such sanction, or judicial review thereof, is pending, unless otherwise ordered by the Secretary or by court order.

[Health Insurance Benefits Advisory Council

[**Sec. 1867.** (a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member

shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

[(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.]

Agreements With Physicians to Accept Assignments

Sec. 1868. *(a) For purposes of this section the term "participating physician" means a doctor of medicine or osteopathy who has in effect an agreement with the Secretary by which he agrees to accept an assignment of claim (as provided for in section 1842(b)(3)(B)(ii)) for each physicians' service (other than those excluded from coverage by section 1862) performed by him in the United States for an individual enrolled under part B. The assignment shall be in a form prescribed by the Secretary. The agreement may be terminated by either party upon thirty days' notice to the other, filed in a manner prescribed by the Secretary.*

(b) To expedite processing of claims from participating physicians, the Secretary shall establish procedures and develop appropriate forms under which—

(1) each physician will submit his claims on one of alternative simplified approved bases including multiple listing of patients, and the Secretary shall act to assure that these claims are processed expeditiously, and

(2) the physician shall obtain from each patient enrolled under part B (except in cases where the Secretary finds it impractical for the patient to furnish it) and shall make available at the Secretary's request, a signed statement by which the patient, for such period of time as may be appropriate (as determined by the Secretary in regulations) (A) agrees to make an assignment with respect to all services furnished by the physician and (B) authorizes the release of any medical information needed to review claims submitted by the physician.

* * * * * * *

Determinations; Appeals

Sec. 1869. (a) * * *

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and op-

portunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). *If the Secretary's determination terminates a provider with an existing agreement pursuant to section 1866(b)(2), or if such determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a final decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if the Secretary certifies that the provider has been notified of such deficiencies and has failed to correct them.*

Overpayments on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals

Sec. 1870. (a) * * *

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

(1) no assignment of the right to payments was made by such individual before his death, and

(2) payment for such services has not been made,

[payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

payment for such services shall be made (but only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died) to—

(A) the physician or other person who provided such services, but only on the condition that such physician or person agrees that the reasonable charge is the full charge for the services, or

(B) the spouse or other legally designated representative of such individual, but only if (i) the condition specified in subparagraph (A) is not met, and (ii) such spouse or representative requests (in such form and manner as the Secretary shall by regulations prescribe) that payment be made under this subparagraph.

(g) If an individual, who is enrolled under section 1818(c) of the Social Security Act or under section 1837, dies, and premiums with respect to such enrollment have been received with respect to such individual for any month after the month of his death, such premiums shall be refunded to the person or persons determined by the Secretary under regulations to have paid such premiums or if payment for such premiums was made by the deceased individual before his death, to the legal representative of the estate of such deceased individual, if

any. If there is no person who meets the requirements of the preceding sentence such premiums shall be refunded to the person or persons in the priorities specified in paragraphs (2) through (7) of subsection (e).

Provider Reimbursement Review Board

Sec. 1878. (a) * * *

(f) (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (*or, in an action brought jointly by several providers, the judicial district in which is located the provider which is the principal party bringing the action*) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of title 5, United States Code, notwithstanding any other provisions in section 205.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a) (3) and equal to the rate of return on equity capital established by regulation pursuant to section 1861 (v) (1) (B) and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this Act.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

State Plans for Medical Assistance

Sec. 1902. (a) * * *

(1) * * *

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan *or any audit or similar activity conducted in connection with the administration of such plan by any governmental entity (including any legislative body or component or instrumentality thereof) which is authorized by law to conduct such audit or activity*;

* * * * * * *

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1905(a), and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1905(a) or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facility during any period he is receiving hospital services from such hospital or skilled nursing facility services from such home, and

[(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and

[(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and]

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, applying the methods specified in section 1861(v) and section 1861(bb), which are consistent with section 1122; and

(E) effective January 1, 1980, for payment of the skilled nursing facility and intermediate care facility services provided under the plan through the use of rates, determined in accordance with methods and standards developed by the State, which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in

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conformity with applicable State and Federal laws, regulations, and quality and safety standards; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each provider of services and periodic audits by the State of such reports; and

(F) for payment for services described in section 1905(a)(2)(B) provided by a rural health clinic under the plan of 100 percent of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary may prescribe in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on such tests of reasonableness as the Secretary may prescribe in regulations under this subparagraph;

* * * * * * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) (*A*) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic, *or* (*B*) *during the three-year period beginning on the date of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that (i) adequate services will be available under such arrangements, (ii) such laboratory services will be provided only through laboratories (I) which meet the requirements of section 1861(e)(9), paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, and (II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII, and (iii) charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in ag-*

gregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services, or (C) has made arrangements through a competitive bidding process or otherwise for the purchase of medical devices which do not vary significantly in quality among suppliers, if the Secretary has found that (i) an adequate supply of such devices will be available under such arrangements, (ii) such devices will be provided only through suppliers no more than 75 percent of whose charges for such devices are for devices provided to individuals who are entitled to benefits under this title or under part A or B of title XVIII, and (iii) charges for devices provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such devices) for comparable devices by the supplier of such devices, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable devices by the supplier of such devices;

* * * * * * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, [and] (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request, *and (C) not to increase amounts due from any individual, organization, or agency in order to offset reductions made pursuant to the requirements contained in section 1902(a)(13)(D) in the amount paid, or expected to be paid under the State plan*;

* * * * * * *

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care, *and, in the case of laboratory services referred to in section 1905(a)(3) and medical devices referred to in section 1902(a)(23)(C), such payments do not exceed the lowest amount charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services or devices) to any person or entity for such services by that provider of laboratory services or medical devices*;

* * * * * * *

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, *and that such determinations shall, if the Secretary has cause to question the adequacy thereof, be subject to validation by the Secretary, who may make independent and binding determinations as to whether such institutions and agencies meet such requirements*;

* * * * *

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title; [and]

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization[.]; *and*

(41) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such

extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such title, and (C) for payment of the portion of the costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII; and

(42) provide that any laboratory services (other than such services provided in a physician's office) paid for under such plan must be provided by a laboratory which meets the requirements of section 1861(e)(9) and paragraphs (10) and (11) of section 1861(s), or, in the case of a rural health clinic, section 1861(aa)(2)(G).

* * * * * * *

Payment to States

Sec. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966.

(1) * * *

(6) subject to subsection (b)(3), an amount equal to 90 per centum of the sums expended during each quarter beginning on or after October 1, 1977, and ending before October 1, [1980] *1982*, with respect to costs incurred during such quarter (as found necessary by the Secretary for the elimination of fraud in the provision and administration of medical assistance provided under the State plan) which are attributable to the establishment and operation of (including the training of personnel employed by) a State medicaid fraud control unit (described in subsection (q)); plus

(7) an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b)(1) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State for any quarter beginning after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 or over and disabled individuals entitled to hospital insurance benefits under title XVIII which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of title XVIII, other than amounts expended under provisions of the plan of such State required by section 1902(a)(34).

(2) For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

(3)(*A*) The amount of funds which the Secretary is otherwise obligated to pay a State during a quarter under subsection (a)(6) may not exceed the higher of—

[(A)] (*i*) $125,000, or

by the Federal, State, and local governments during the previous quarter in carrying out the State's plan under this title.

(B) No amount shall be paid to any State under subsection (a)(6) with respect to sums expended during any quarter after the twelve-quarter period which commences with the first quarter with respect to which an amount is paid to such State under subsection (a)(6).

(c) [Repealed.]

(d)(1) Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsections (a) and (b) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

(2) The Secretary shall then pay to the State, in such installments as he may determine, the amounts so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection. Expenditures for which payments were made to the State under subsection (a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 1902(a)(25). *In determining the installments under this paragraph the Secretary shall insure that payments to States are not made prior to the time that checks issued by the State for the medical assistance or other expenditure for which the Federal payment is being made are cleared through the State depository for payment.*

(3) The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

(4) Upon the making of an estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)] *subparagraphs (B)(ii), (B)(iii), (C) and (F) of section 1842(b)(4)*; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

* * * * * * *

(m)(1)(A) The term "health maintenance organization" means a legal entity which provides health services to individuals enrolled in such organization and which—

(i) provides to its enrollees who are eligible for benefits under this title the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905, and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a);

(ii) provides such services and benefits in the manner prescribed in section 1301(b) of the Public Health Service Act (except that, solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section, shall be deemed to refer to the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a), and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the

services and benefits described in paragraph (7) of section 1905 (a)); and

(iii) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act (except that solely for purposes of this paragraph, the term "basic health services" and references thereto, when employed in such section shall be deemed to refer to the services and benefits described in section 1905(a) (1), (2), (3), (4)(C), and (5), and to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of section 1905(a)).

(B) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a health maintenance organization within the meaning of subparagraph (A), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1); and

(ii) less than one-half of the membership of the entity consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title.

(B) Subparagraph (A) does not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services provided by an entity which—

(i)(I) received a grant of at least $100,000 in the fiscal year ending June 30, 1976, under section 319(d)(1)(A) or 330(d)(1) of the Public Health Service Act, and (II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title has been the recipient of a grant under either such section; and

(II) provides to its enrollees, on a prepaid capitation risk basis or on any other risk basis, all of the services and benefits described in paragraphs (1), (2), (3), (4)(C), and (5) of section 1905(a) and, to the extent required by section 1902(a)(13)(A)(ii) to be provided under a State plan for medical assistance, the services and benefits described in paragraph (7) of such section; or

(ii) is a nonprofit primary health care entity located in a rural area (as defined by the Appalachian Regional Commission)—

(I) which received in the fiscal year ending June 30, 1976, at least $100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, and

(II) for the period beginning July 1, 1976, and ending on the expiration of the period for which payments are to be made under this title either has been the recipient of a grant, subgrant, or subcontract under such Act or has provided services under a contract (initially entered into during a year in which the entity was the recipient of such a grant, subgrant, or subcontract) with a State agency under this title on a prepaid capitation risk basis or on any other risk basis; or

(iii) which has contracted with the single State agency for the provision of services (but not including inpatient hospital services) to persons eligible under this title on a prepaid risk basis prior to 1970.

(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity enters into a contract with the State under this title for the provision of health services on a prepaid risk basis, whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

(3) A State may, in the case of an entity which has submitted an application to the Secretary for determination that it is a health maintenance organization within the meaning of paragraph (1) and for which no such determination has been made within 90 days of the submission of the application, make a provisional determination for the purposes of this title that such entity is such a health maintenance organization. Such provisional determination shall remain in force until such time as the Secretary makes a determination regarding the entity's qualification under paragraph (1).

* * * * * * *

(*r*) *In the administration of this title, the fact that an individual who is an inpatient of a skilled nursing or intermediate care facility leaves to make visits outside the facility shall not conclusively indicate that he does not need services which the facility is designed to provide; however, the frequency and length of such visits shall be considered, together with other evidence, in determining whether the individual is in need of the facility's services.*

(*s*) *For additional exclusions from reasonable cost and reasonable charge see section 1134.*

Operation of State Plans

Sec. 1904. (*a*) If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

(*b*) *The Secretary shall not find that a State has failed to comply with the requirements of this title solely because it denies medical assistance to an individual who would be ineligible for benefits under title XVI of this Act, or, in the case of an individual who is not included under section 1902(a)(10)(A), would be ineligible for medical assistance under the State plan, if there was included in his resources any asset owned by him within the preceding twelve months to the extent that he gave or sold that asset to any person for substantially less than its fair market value for the purpose of establishing eligibility for medical assistance under the State plan (and any such transaction shall be presumed to have been for such purpose unless such individual furnishes convincing evidence to establish that the transaction was for some other purpose).*

* * * * * * *

Certification and Approval of Skilled Nursing Facilities and of Rural Health Clinics

Sec. 1910. (a)(1) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

(*c*)(*1*) *The Secretary may cancel approval of any skilled nursing or intermediate care facility at any time if he finds on the basis of a determination made by him as provided in section 1902(a)(33)(B) that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In*

that event the Secretary shall notify the State agency and the skilled nursing or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in the programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(2) Any skilled nursing facility or intermediate care facility which is dissatisfied with any determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title, shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determniation, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

(d) (1) If the Secretary determines that a skilled nursing facility or intermediate care facility fails to meet the requirements of section 1902(a) (28) or 1905(c) (as the case may be), and determines that such failure does not jeopardize the health or safety of patients in such facility, he may, instead of cancelling approval of such facility under subsection (c), impose an intermediate sanction, consisting of a reduction in the amount of reimbursement to be made with respect to such facility or a restriction on the number or kinds of patients for whom reimbursement may be made under the State plan or under title XVIII to such facility, until such time as the failure is corrected.

(2) The Secretary may impose an intermediate sanction under paragraph (1) after giving notice to the facility of his intent to impose the sanction and allowing such facility a reasonable period of time (as determined by the Secretary) in which to correct the failure. Any facility which is dissatisfied with a determination by the Secretary to impose an intermediate sanction upon such facility shall be entitled to a hearing by the Secretary, wthin 30 days after such sanction is imposed, to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any intermediate sanction imposed by the Secretary shall remain in effect during any period in which a hearing on such sanction, or judicial review thereof, is pending, unless otherwise ordered by the Secretary or by court order.

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HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under an approved State plan for skilled nursing services and intermediate care

services furnished by a hospital which has in effect an agreement under section 1861(dd) of this Act.

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care services furnished pursuant to subsection (a), shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has in effect an agreement under section 1861(dd), in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services due from all classes of long-term care patients, including title XVIII, the State plan, and private pay patients, shall be subtracted from the hospital's total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

EXCERPTS FROM PUBLIC LAW 90–248, AS AMENDED

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TITLE IV—GENERAL PROVISIONS

INCENTIVES FOR ECONOMY WHILE MAINTAINING OR IMPROVING QUALITY IN THE PROVISION OF HEALTH SERVICES

Sec. 402. (a)(1) The Secretary of Health, Education, and Welfare is authorized, either directly or through grants to public or nonprofit private agencies, institutions, and organizations or contracts with public or private agencies, institutions, and organizations, to develop and engage in experiments and demonstration projects for the following purposes:

(A) to determine whether, and if so which, changes in methods of payment or reimbursement (other than those dealt with in section 222(a) of the Social Security Amendments of 1972) for health care and services under health programs established by the Social Security Act, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services;

(B) to determine whether payments for services other than those for which payment may be made under such programs (and which are incidental to services for which payment may be made under such programs) would, in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program, where such services are furnished by organizations and institutions which have the capability of providing—

(i) comprehensive health care services,

(ii) mental health care services (as defined by section 401(c) of the Mental Retardation Facilities and Community Health Centers Construction Act of 1963),

(iii) ambulatory health care services (including surgical services provided on an outpatient basis), or

(iv) institutional services which may substitute, at lower cost, for hospital care;

(C) to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by the Social Security Act, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;

(D) to determine whether payments under such programs based on a single combined rate of reimbursement or charge for the teaching activities and patient care which residents, interns, and supervising physicians render in connection with a graduate medical education program in a patient facility would result in more equitable and economical patient care arrangements without adversely affecting the quality of such care;

(E) to determine whether coverage of intermediate care facility services and homemaker services would provide suitable alternatives to posthospital benefits presently provided under title XVIII of the Social Security Act; such experiment and demonstration projects may include:

(i) counting each day of care in an intermediate care facility as one day of care in a skilled nursing facility, if such care was for a condition for which the individual was hospitalized,

(ii) covering the services of homemakers for a maximum of 21 days, if institutional services are not medically appropriate,

(iii) determining whether such coverage would reduce long-range costs by reducing the lengths of stay in hospitals and skilled nursing facilities, and

(iv) establishing alternative eligibility requirements and determining the probable cost of applying each alternative, if the project suggests that such extension of coverage would be desirable;

(F) to determine whether, and if so which type of, fixed price or performance incentive contract would have the effect of inducing to the greatest degree effective, efficient, and economical performance of agencies and organizations making payment under agreements or contracts with the Secretary for health care and services under health programs established by the Social Security Act; and

(G) to determine under what circumstances payment for services would be appropriate and the most appropriate, equitable, and non-inflationary methods and amounts of reimbursement under health care programs established by the Social Security Act for services, which are performed independently by an assistant to a physician, including a nurse practitioner (whether or not performed in the office of or at a place at which such physician is physically present), and—

(i) which such assistant is legally authorized to perform by the State or political subdivision wherein such services are performed, and

(ii) for which such physician assumes full legal ethical responsibility as to the necessity, propriety, and quality thereof;

(H) to establish an experimental program to provide day-care services, which consist of such personal care, supervision, and services as the Secretary shall by regulation prescribe, for individuals eligible to enroll in the supplemental medical insurance program established under part B of titles XVIII and XIX of the Social Security Act, in day-care centers which meet such standards as the Secretary shall by regulation establish;

(I) to determine whether the services of clinical psychologists may be made more generally available to persons eligible for services under titles XVIII and XIX of this Act in a manner consistent with quality of care and equitable and efficient administration; [and]

(J) to develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act. [/]; *and*

(K) to determine methods for increasing the rate of physician acceptance of assignments under title XVIII of the Social Security Act, especially in States which have low assignment rates, through not more than 10, nor less than 5, demonstration projects, the results of which shall be reported to the Congress along with recommendations for increasing such assignment rates, and which may include, but are not limited to, any of the following—

(i) payment of cost savings allowances to participating physicians who submit claims in multiple listing format;

(ii) provision of incentive payments to physicians who agree to accept the medicare allowable charge as the full charge;

(iii) publication of consumer directories listing physicians who agree to accept assignments;

(iv) encouragement of physician assignments through public education programs;

(v) development of other systems of financial incentives for physicians to accept assignments, which are developed through consultation with the medical community;

(vi) payment at a rate of 100 percent of the allowable charge where services are provided by a physician who has accepted an assignment;

(vii) distribution of information to physicians concerning the medicare prevailing charge levels in any area; and

(viii) the use of prospective reimbursement to physicians on a periodic basis, based on prior reimbursement rates.

For purposes of this subsection, "health programs established by the Social Security Act" means the program established by title XVIII of such Act, a program established by a plan of a State approved under title XIX of such Act, and a program established by a plan of a State approved under title V of such Act.

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EXCERPTS FROM PUBLIC LAW 93–233, AS AMENDED

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Payment for Services of Physicians Rendered in a Teaching Hospital

Sec. 15. (a)(1) Notwithstanding any other provision of law, the provisions of section 1861(b) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if paragraph (7) of such section read as follows:

"(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title."

(2) Notwithstanding any other provision of law, the provisions of section 1832(a)(2)(B)(i) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if subclause II of such section read as follows:

"(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section are met, and".

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(d) The provisions of subsection (a) shall apply with respect to cost accounting periods beginning after June 30, 1973, and prior to October 1, [1978] *1979*.

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EXCERPTS FROM PUBLIC LAW 93–445

TITLE I—THE RAILROAD RETIREMENT ACT OF 1974

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SEC. 7. (a) * * *

(d)(1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, posthospital extended care services, [posthospital] home health services, and outpatient hospital diagnostic services (all hereinafter referred to as 'services') under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals

to whom such sections and such parts apply. For purposes of section 8, a determination with respect to the rights of an individual under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

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